Dr. Steven Lemberger

PATIENT REGISTRATION FORM

PATIENT LAST NAME	FIRST	MI	( )FEMALE ( )MALE	BIRTHDATE	AGE	HOME PHONE

ADDRESS	SOCIAL SECURITY NO.	MARITAL STATUS S M W D	WORK PHONE

CITY	STATE	ZIP	ARE YOU EMPLOYED? ( )YES ( )NO	OCCUPATION

EMPLOYER

EMPLOYER ADDRESS	PHONE

EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE

INSURANCE COMPANY **PRIMARY**	EFFECTIVE DATE	INSURANCE COMPANY **SECONDARY**	EFFECTIVE DATE

POLICY NO	GROUP NO.	POLICY NO.	GROUP NO

POLICYHOLDER: _____

SOCIAL SECURITY NO. _____

DATE OF BIRTH: _____ SEX _____

RELATIONSHIP TO PATIENT _____

POLICYHOLDER: _____

SOCIAL SECURITY NO. _____

DATE OF BIRTH _____ SEX _____

RELATIONSHIP TO PATIENT _____

IS THIS AN INJURY? ( ) YES ( ) NO	IF INJURY, HOW DID IT OCCUR? ( ) WORK ( ) MOTOR VEHICLE ( ) OTHER	DATE OF INJURY

INSURANCE CARRIER NAME / ADDRESS	CLAIM NUMBER

PERSON TO CONTACT AT INSURANCE CARRIER	PHONE NUMBER

IF WORKER'S COMP, PERSON TO CONTACT AT YOUR EMPLOYMENT	PHONE NUMBER

Assignment of Benefits/ Financial Policy

I hereby assign or transfer payment benefits made to me or on my behalf to *Dr. Steven Lemberger* for services furnished to me. I have read and agree to pay any amount due, according to the financial policy.

Release of Information

I hereby authorize *Dr. Steven Lemberger* to release information acquired during the course of my examination or treatment, to my referring physician or to an appropriate insurance carrier, that may be necessary for further medical care and reimbursement of services rendered.

Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice

Patient Signature_____ Date_____

(Parent or Guardian if minor)

Medical Information

Describe the reason you are seeing the Doctor: _____

How long has the condition existed? _____ **Where is it located?** ____ left ____ right

Describe the pain: ___ Shooting ___ Throbbing ___ Burning ___ Itching ___ Aching

___ Tenderness ___ Dull ___ Numbness ___ Other _____

Has this condition been treated by another physician? ___ Yes ___ No

Describe treatment: _____

Family Physician: _____ **Date of last visit:** _____

Allergies:
___ Adhesive tape
___ Aspirin
___ Codeine
___ Iodine
___ Novocain
___ Penicillin
___ Shellfish
___ Sulfa
___ Other _____

Family History:
___ Bunions
___ Cancer
___ Heart Disease
___ Diabetes
___ Flat Feet
___ Gout
___ Other _____

Current Medications: _____

Past Medical History:
___ Anxiety
___ Arthritis
___ Asthma
___ Cancer
___ Cardiac Disease
___ Depression
___ Diabetes
___ Glaucoma
___ Fractures
___ GI Ulcers
___ Gout
___ Blood Pressure
___ Lipid Elevation
___ Murmur
___ Neuropathy
___ Osteoporosis
___ Poor Circulation
___ Thyroid Disease
___ Other _____

Please check all that apply to you:
___ allergic responses
___ ankle swelling
___ bleeding problems
___ breathing problems
___ calf pain
___ cold feet
___ currently pregnant
___ hearing problems
___ dry skin
___ edema
___ eye / vision problems
___ fever
___ stomach problems
___ gout
___ high sugar
___ hypersensitivity of skin
___ hypertrophic scars
___ joint pain
___ murmur
___ nausea
___ numbness
___ growth spurt
___ sleeping problems
___ tingling sensation
___ ulcerations
___ fatigue
___ increased urination
___ weakness

Past Surgical History: _____

Social History: Do you smoke? ___ Yes ___ No Do you drink alcohol? ___ Yes ___ No

How were you referred to our office? _____