Jeffrey Paul Edelstein, M.D., Ltd.
2905 West Warner Road, Suite 20
Chandler, AZ 85224

Patient Name:
DOB:
Age:
Gender:
Date:

Patient Registration

Patient Full Name: _____

Local Address: _____ **City:** _____ **State:** **Zip:** _____

Alternate Address: _____ **City:** _____ **State:** **Zip:** _____

Phone #: _____ **Work #:** _____ **Cell #:** _____

Birthdate: _____ **Social Security #:** _____ **Marital Status:** **S M W** **Sex: M F**

Patient Email: _____

Emergency Contact Name and Phone: _____ #

Patient Occupation: _____ **Employer:** _____

Primary Doctor Name-Phone _____

Referral Source: _____ **Preferred Language**: _____

Responsible Party (Guarantor/policy holder): _____

Patient Relationship to Insured: **( ) Self** **( ) Spouse** **( ) Child** **( ) Employee**

Birthdate: _____ **Social Security #:** _____

Address-Phone: _____

If Accident, Date of Accident: _____ **Workers Compensation:** **Y N**

Insurance and Billing Policy

We are providing this information to avoid confusion regarding our office billing policy. We are working to provide high quality care for your benefit and our contract is directly with YOU, the patient. All care is charged directly to you and you are responsible for payment. We do not render services on the assumption that your charges will be paid by your insurance carrier. We do share a relationship with certain insurance companies, please ask us if your insurance is one of them. We are a participating Medicare provider, which means that YOU are responsible for the 20% of Medicare Allowed Amounts and 100% of Non-Covered Medicare Services (i.e.. Cosmetic surgery)

As a courtesy to our patients, we will gladly submit claims to primary and secondary insurance on your behalf. In addition, we will provide supporting documentation and letters to support your claim. However, it is YOUR responsibility to contact the insurance company when pre-authorization is required.

You will receive regular monthly statements from our office indicating the status of your bill. You are responsible for the bill and payment is required prior to cosmetic surgery, and at the time of office visits. Insurance deductibles and patient portions (ie.20%) shall be remitted no later than the next monthly billing cycle. Insurance payments shall be forwarded, upon receipt. In the event of delayed or denied insurance claims, payment in full, is expected after ninety (90) days from the date of service.

When appropriate, we are willing to work with you to provide interest free payment plans to suit your budgetary needs. However if this privilege is abused, interest will accrue at 1.5% monthly. The financial agreement for services provided by Jeffery Paul Edelstein, M.D. is binding. While we are willing to work with our patients to meet their financial obligations, the responsibility for payments remains with you. The failure to fulfill this obligation may result in legal action with the patient responsible for any incurred legal/court/collection/attorney fees.

Payment to Physician/Release of Medical Information

I hereby authorize my insurance benefits for services rendered to be paid directly to Jeffrey Paul Edelstein, M.D. I also authorize Dr Edelstein to furnish copies of my medical records for processing insurance claims, disability requests, employer requests, family members and requesting physicians. I also authorize your facility/physician to release all requested medical information TO Jeffrey Paul Edelstein, M.D.
EXCEPT FOR: _____

I have read and agree to abide by the above policies. My signature indicates that I fully understand the contents of this sheet and I have no further questions.

SIGNATURE _____ **DATE:** _____

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Medications

Please list the dose and frequency of all current medications:

Preferred Pharmacy: _____ Crossroads: _____

Please list any BLOOD THINNERS you are taking:

ASPIRIN PERSANTINE PLAVIX ECOTRIN COUMADIN ADVIL NAPROSYN MOTRIN/IBUPROPHEN

Other: _____

Allergies/Drug reactions

Please list any known allergies or drug intolerances and describe what happened:

The information below is being collected by federal mandate under the Affordable Care Act.

You may read about the legislation a www.healthcare.gov/law/full

Have you ever been diabetic? **Yes** **No** **Who manages your diabetes:** _____

Have you ever had glaucoma? **Yes** **No** _____

Do you have high blood pressure? **Yes** **No**

Have you ever received a pneumococcal vaccination? **Yes** **No** **Date of last vaccination:** _____

Please check the appropriate box below:

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian
☐ Type-Unknown ☐ White ☐ I decline to disclose race.

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type-Unknown ☐ I decline to disclose ethnicity.

Smoking Status:

☐ Current, every day smoker ☐ Current, some day smoker ☐ Never Smoker
☐ Former Smoker ☐ Unknown if ever smoked

How much do (did) you smoke per day? _____ When did you start? _____
When did you quit? _____

Height/Weight (to calculate your body mass index) : _____

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Past Medical History

What is the reason you need to see the doctor today? _____

Who referred you to our office? _____

Who is your primary care physician? _____

Past Surgery/Hospitalizations

_____

_____

_____

_____

Past Social History

Living Arrangements: ( ) Home/Self Care ( ) Family Care ( ) Nursing Care

Occupation: _____ Drug/Alcohol use and frequency: _____

Birthplace: Foreign Travel:

Review of Systems

Do you now or have you had any problems related to the following systems? Circle YES or NO on each question.
Please explain YES answers on the back of this page.

Females: Are you pregnant or trying to become pregnant? Y N

Constitutional Symptoms			**Integumentary**		
Fever	Y	N	Skin Rash	Y	N
Chills	Y	N	Hair loss/Nail changes	Y	N
Headache	Y	N	Persistent Itch	Y	N
Weight loss	Y	N	Bruising/Bleeding	Y	N
Eyes			**Musculoskeletal**		
Loss of Vision	Y	N	Joint Pain	Y	N
Double Vision	Y	N	Neck Pain	Y	N
Pain	Y	N	Back Pain	Y	N
Color Blindness	Y	N	Weakness	Y	N
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**		
Hay Fever	Y	N	Ear infection	Y	N
Drug Allergies	Y	N	Sore Throat	Y	N
Neurological			Sinus Problem	Y	N
Facial Weakness	Y	N	Hearing disorder	Y	N
Seizure disorder	Y	N	**Genitourinary**		
Tremors	Y	N	Urine Retention	Y	N
Dizzy Spells	Y	N	Painful/bloody urination	Y	N
Numbness/Tingling	Y	N	Urinary Frequency	Y	N
Smell/taste difficulty	Y	N	Stones	Y	N
Endocrine			**Respiratory**		
Excessive Thirst	Y	N	Wheezing	Y	N
Too hot/cold	Y	N	Frequent Cough	Y	N
Tired/Sluggish	Y	N	Shortness of Breath	Y	N
Abnormal Growth	Y	N	Bronchitis	Y	N
Gastrointestinal			**Hematologic/Lymphatic**		
Abdominal Pain	Y	N	Swollen/painful Glands	Y	N
Nausea/vomiting	Y	N	Blood clotting problem	Y	N
Indigestion/heartburn	Y	N	Anemia	Y	N
Blood in stool	Y	N	Cancer	Y	N
Cardiovascular			**Psychologic**		
Exertional chest pain	Y	N	Are you generally satisfied with your life?	Y	N
Shortness of breath	Y	N	Do you feel severely depressed?	Y	N
Rheumatic fever	Y	N	Have you considered suicide?	Y	N
Hypertension	Y	N	Mood swings	Y	N
Heart palpitations	Y	N			
Swelling	Y	N	**Physicians Signature/Date:**		