J. Scott Robertson, M.D.
Patient Registration

Today's Date: _____ Referring Doctor: _____

Social Security Number: _____

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip code: _____

Sex ○Male ○Female Date of Birth: _____ Race: _____

Ethnicity (please circle one) ○Caucasian ○Hispanic ○Not Hispanic ○Prefer Not to Answer

Marital Status (please circle one) ○Single ○Married ○Divorced ○Widowed

Primary Language: _____

Home Number: _____

Work Phone: _____ Employer Name: _____

Cell Phone: _____

Do you authorize our office to send phone call reminders? ○Yes ○No Text Reminders? ○Yes ○No

Email address: _____

Emergency Contact Name: _____ Phone Number: _____

Insurance Information

Primary Insurance Company Name: _____ Contract ID: _____

Primary Subscriber Name: _____ Subscriber Date of Birth: _____

Secondary Insurance Company Name: _____ Contract ID: _____

Secondary Subscriber Name: _____ Subscriber Date of Birth: _____

List who is responsible for receiving all financial statements:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to pay directly to the physician. I understand I am financially responsible for any balance. I also authorize J. Scott Robertson, M.D. or my insurance company to release any information required to process my claim.

Patient or Guardian Signature: _____ Date: _____

J. Scott Robertson, M.D.

MEDICAL INFORMATION FORM

Name:_____ **DOB:**_____ **Today's date:**_____

How did you hear about us: _____ **Pharmacy & Location:**_____

Reason for Visit:_____

Length of time you have had this problem:_____

Medications you have taken for this problem?_____

Current Medications and Dosage: (All medications including over the counter and vitamins)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies and Reactions:_____

Medical History: (please choose yes or no for any medical problems you have had)

Heart Attack	O Y O N	Acid Reflux	O Y O N	Anemia	O Y O N
Heart Disease	O Y O N	Hiatal Hernia	O Y O N	Hemophilia	O Y O N
Irregular Rhythm	O Y O N	Diabetes	O Y O N	Bleeding Issues	O Y O N
Vascular Disease	O Y O N	Tuberculosis	O Y O N	Blood Clot	O Y O N
High Blood Pressure	O Y O N	Thyroid Disease	O Y O N	Transfusions	O Y O N
Stroke	O Y O N	Kidney Disease	O Y O N	Arthritis	O Y O N
Emphysema/COPD	O Y O N	HIV (AIDS)	O Y O N	Hepatitis	O Y O N
Asthma	O Y O N	Immune Deficiency	O Y O N	Cancer	O Y O N

Other Medical Problems:_____

Surgical History: List previous surgical procedures & date performed:

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL INFORMATION FORM (CONTINUED)

Family History: (please choose yes or no)

Hearing Loss	OYON	Allergies/Sinus Problems	OYON
Bleeding Problems	OYON	Anesthesia Problems	OYON

Social History:

Do you/have you ever smoked? _____ How many years?_____

Any other forms of tobacco? _____

Do you drink alcohol?_____ Drinks per week? _____

Do you use any recreational drugs? _____

Height: _____ **Weight:** _____

Review of Systems: Do you have or have you recently had any of the following? (choose Y or N)

Fatigue	OYON	Change in vision	OYON	Voice change	OYON
Fever	OYON	Double vision	OYON	Enlarged lymph nodes	OYON
Loss of appetite	OYON	Cough	OYON	Chest Pain	OYON
Night sweats	OYON	Nosebleeds	OYON	Shortness of breath	OYON
Weight loss	OYON	Decrease smell	OYON	Nausea/Vomiting	OYON
Seasonal allergie	OYON	Nasal congestion	OYON	Heartburn or reflux	OYON
Facial pressure	OYON	Postnasal drip	OYON	Easy bleeding	OYON
Headache	OYON	Runny nose	OYON	Rash or hives	OYON
Dizziness	OYON	Snoring	OYON	Numbness/tingling	OYON
Ear drainage	OYON	Mouth sores	OYON	Seizures	OYON
Ear pain	OYON	Problems swallowing	OYON	Migraine	OYON
Ear fullness	OYON	Painful swallowing	OYON	Depression	OYON
Hearing loss	OYON	Throat Pain	OYON		
Ear ringing	OYON				

Are you on any blood thinners (e.g. aspirin, Vitamin E, Fish Oil)? _____

Do you have Sleep Apnea? OY ON **Have you had a sleep study?** OYON

If YES date of sleep study: _____ **Location:** _____

Physician & Nurses notes

J. Scott Robertson, M.D., P.C.

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding protected health information. I understand this information can and will be used for payment, for treatment and for health care operations.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses of my health information. I understand that J. Scott Robertson, M.D., has the right to change its Notice of Privacy Practices and I may contact J. Scott Robertson, M.D., to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that J. Scott Robertson, M.D., restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that J. Scott Robertson, M.D., is not required to agree to my requested restrictions, but if the practice does agree then the practice is bound to abide by such restrictions. **I understand this form is required to be signed on an annual basis however I am waiving that right and the below signature is to remain active until I leave the practice. I understand that at any time I may request an updated copy of HIPAA and my signature will be required at that time.**

Patient or Guardian Signature_____Date: _____

Financial Acknowledgement/Considerations

I acknowledge that certain procedures Dr. Scott Robertson recommends (scopes, testing, lesions removals, etc.) may be applicable towards my deductible or I may be billed a certain percentage based on my individual contract with my insurance carrier. This may result in a charge greater than my copay and I accept financial responsibility and agree to make payments in a timely manner. I understand that the billing department of Scott Robertson M.D. is happy to go over any questions before any recommend procedure. I further understand that the office of J. Scott Robertson MD observes the following financial policies: (A) A nonrefundable $50.00 charge will be billed to my account for all "no show" appointments, (B) A $250.00 surgery deposit will be required at the time of scheduling surgery and if surgery is cancelled within 72 hours this is a nonrefundable deposit, (C) A $25.00 forms fee will be charged for any forms filled out by the office of J. Scott Robertson MD.

Patient or Patient Guardian Signature: _____Date: _____

Patient Contact Information

Patient Name: _____ Date: _____

J. Scott Robertson, M.D., or any staff member has my permission to discuss my account and medical conditions which may include symptoms, treatment, diagnosis, test results, medications, or any other protected health information with my **Emergency Contact** and the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that authorizing the release of my information to the above individuals is voluntary. The authorization will remain in effect until I change it.

Patient or Guardian Signature: _____Date: _____