

PATIENT REGISTRATION

DATE \_\_\_\_\_ FAMILY/REFERRING DR. \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_/\_\_\_/\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMAIL \_\_\_\_\_ DRIVERS LICENSE \_\_\_\_\_

PATIENT S.S. # \_\_\_\_\_ PHONE \_\_\_\_\_ AGE \_\_\_\_\_

SEX M  F  MARITAL STATUS S  M  W  D  Cell Phone \_\_\_\_\_

PATIENT EMPLOYER & ADDRESS \_\_\_\_\_

EMPLOYER PHONE \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_ IS VISIT DUE TO AN INJURY  YES  NO

REFERRED BY WHOM \_\_\_\_\_

SPOUSE OR NEAREST RELATIVE \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

RESPONSIBLE PERSON NAME \_\_\_\_\_ S.S. # \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

EMPLOYER & ADDRESS \_\_\_\_\_

INSURANCE INFORMATION

PRIMARY CARRIER \_\_\_\_\_ Card Holder Name \_\_\_\_\_

ADDRESS \_\_\_\_\_ Card Holder Date of Birth \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ PLAN \_\_\_\_\_

SECONDARY CARRIER \_\_\_\_\_ Card Holder Name \_\_\_\_\_

ADDRESS \_\_\_\_\_ Card Holder Date of Birth \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ PLAN \_\_\_\_\_

I HEREBY AUTHORIZE DR. PECK, AND WHERE APPLICABLE, ESSEX SURGICAL, LLC, AND/OR THE ANESTHESIOLOGIST TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PREVIOUSLY NAMED PARTIES TO BE MADE TO HIM/THEM REGARDLESS OF MY INSURANCE BENEFITS. PHOTOCOPIES OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED, OUTSIDE LABORATORY FEES ARE THE PATIENTS RESPONSIBILITY. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THIS MAY INCLUDE FAXING INFORMATION FOR HEALTHCARE PURPOSES AND BILLING, AS WELL AS LEAVING MESSAGES FOR APPOINTMENTS AND HEALTH CARE (PRE/POST OPERATIVE CALLS ARE INCLUDED).

NAME \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT SIGNATURE/RESPONSIBLE PERSON \_\_\_\_\_

# ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

YOUR NAME \_\_\_\_\_ DATE \_\_\_\_\_

	YES	NO	EFFECT		YES	NO	EFFECT
PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	_____	TAPE	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER MEDICATION	<input type="checkbox"/>	<input type="checkbox"/>	_____	HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	_____	SHELL FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
CONTACT ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	_____	SHELL FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____

EXPLAIN ALLERGIC EFFECTS: \_\_\_\_\_  
 DATE OF LAST TETANUS SHOT: \_\_\_\_\_

## ILLNESS & MEDICAL PROBLEMS:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ANESTHESIA PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER EYE TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	DIVERTICULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	EAR TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MONONUCLEOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DEAF OR HEARING IMP.	<input type="checkbox"/>	<input type="checkbox"/>	GALL BLADDER TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	SLEEP APNEA/DISORDERS
<input type="checkbox"/>	<input type="checkbox"/>	SWELLING IN NECK	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS/SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HEALING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY / BLADDER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HERNIAS	<input type="checkbox"/>	<input type="checkbox"/>	VARICOSE VEINS
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BLEED EASILY
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	EYE PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	CANCER:
<input type="checkbox"/>	<input type="checkbox"/>	ANKLE SWELL	<input type="checkbox"/>	<input type="checkbox"/>	YEAR / TYPE _____
<input type="checkbox"/>	<input type="checkbox"/>	MENTAL / NEUROLOGICAL CONDITION:			
		_____			

HAVE YOU HAD A MOLE SCREENING?  
DATE: \_\_\_\_\_

DO YOU HAVE ANY MOLES / BEAUTY MARKS WHICH ARE IRREGULAR, MULTI-COLORED, OR HAVE CHANGED?

## WOMEN ONLY

<input type="checkbox"/> TENDER BREASTS	<input type="checkbox"/> LUMPS OR OR RECENT SIZE/COLOR CHANGE
<input type="checkbox"/> FIBROCYSTIC DISEASE	PREVIOUS MAMMOGRAM YEAR: _____
<input type="checkbox"/> MENSTRUAL PROBLEM	LAST MENSTRUAL PERIOD: _____
<input type="checkbox"/> WERE YOUR CHILDREN BREAST FED	NUMBER OF CHILDREN: _____
<input type="checkbox"/> DO YOU PLAN TO HAVE CHILDREN?	

HAVE ANY OF THE ABOVE CONDITIONS APPEARED IN YOUR IMMEDIATE FAMILY? IF SO, SPECIFY: \_\_\_\_\_

MEDICAL HISTORY

YOUR NAME \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

SURGERY (OPERATIONS):

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

ADMISSIONS TO HOSPITALS:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

MEDICATIONS (ANY DRUG OR MEDICATION) YOU TAKE NOW:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

OVER THE COUNTER MEDICATION INCLUDING HERBAL SUPPLEMENTS

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

CONSUMPTION OF THE FOLLOWING:

Aspirin _____	Amount Daily _____	Amount Weekly _____
Alcohol _____	Amount Daily _____	Amount Weekly _____
Tobacco _____	Amount Daily _____	Amount Weekly _____

BLEEDING PROBLEMS: (WITH CUTS? TOOTH EXTRACTIONS? PREGNANCY? SURGERY?)  
EXPLAIN:

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:  
EXPLAIN:

FAMILY HISTORY OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:  
EXPLAIN:

FAMILY HISTORY: ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

Mother _____	Father _____
Sister _____	Brother _____
_____	_____

**THE PECK CENTER, INC.**  
**ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION**

Patient Name \_\_\_\_\_ Claim # \_\_\_\_\_

I hereby authorize **DR. PECK/PECK CENTER, INC.,** to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependants, to the facility/ physicians. I understand that I am responsible for any amount not covered by my insurance. I UNDERSTAND THAT IF MY INSURANCE COMPANY HAS STATED MY COVERAGE HAS BEEN TERMINATED THAT I AM PERSONALLY RESPONSIBLE FOR ANY MEDICAL AND/OR FACILITY FEES CONCERNING MY ILLNESS AND TREATMENTS..

I am assigning all my rights unconditionally to t **DR. PECK/PECK CENTER, INC.,** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

X \_\_\_\_\_  
Patient or Responsible Party's Signature

**No FAULT, VICTIMS OF CRIMES AND/OR WORKERS COMPENSATION PATIENTS**

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney: \_\_\_\_\_. I further authorize **DR. PECK/PECK CENTER, INC.,** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will *only* be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, for which I am responsible.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependants and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed, will arbitrate my bills for payment.

X \_\_\_\_\_  
Patient or Responsible Party's Signature

**ATTORNEY INFORMATION**

Attorney Name: \_\_\_\_\_ Attorney Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_