J. Scott Robertson, M.D.

Patient Registration

Today's Date: _____

Referring Doctor: _____

Social Security Number: _____

Date of Birth: _____

Last Name: _____ First Name:_____

Street Address:_____City:_____

State:_____ Zip Code:_____

Sex: Male or Female

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 Number:_____Employer Name:_____

Cell Number:_____

Do you authorize this office to call with appointment reminders? Yes or No Text? Yes or No

Cell Phone Carrier: _____(please provide to receive appointment reminders)

Email Address:_____

Emergency Contact Name:_____Phone Number:_____

Insurance Information

Primary Insurance Company:_____Contract ID:_____

Primary Subscriber Name:_____Date of Birth:_____

Secondary Insurance Company:_____Contract ID:_____

Secondary Subscriber Name:_____Date of Birth:_____

Person responsible for receiving all financial statements:

Name:_____ Street Address:_____

City:_____State:_____Zip Code:_____

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

Patient or Guardian Signature:_____ Date: _____

MEDICAL INFORMATION FORM

Name: _____DOB: _____Today's Date: _____

How did you hear about us: _____Pharmacy & Location: _____

Primary Care Physician: _____

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	Yes	No		Yes	No		Yes	No
Heart Attack			Acid Reflux			Hemophilia		
Heart Disease			Hiatal Hernia			Bleeding Issues		
Irregular heart Rhythm			Diabetes			Blood Clot		
Vascular Disease			Liver Disease			Transfusions		
High Blood pressure			Thyroid Disease			Arthritis		
Stroke			Kidney Disease			Hepatitis		
Emphysema/COPD			Anemia			Cancer		
Asthma			Immune Deficiency					

Medical History: (Please choose yes or no for any medical problem you have had)

Other Medical Problems: _____

_____

Surgical History: List previous surgical procedures & date preformed:

_____ _____ _____

_____ _____ _____

J SCOTT ROBERTSON M.D. 2001 Providence Park Birmingham, AL 35242 205.982.7220

MEDICAL INFORMATION FORM (CONTINUED)

Family History: (Please choose yes or no)

Hearing Loss	Y	N	Allergies/Sinus Problems	Y	N
Bleeding Problems	Y	N	Anesthesia Problems	Y	N

Social History:

Tobacco Use: Y N FORMER If yes or quit, how many years did or have you smoke(d) _____

How Many packs a day: _____ If smokeless, how much: _____

Do you drink alcohol Y N How many drinks per week: _____

Do you use recreational drugs Y N Type: _____

Height: _____ Weight: _____

Review of Systems: Do you have or have you recently had any of the following? (Choose yes or no)

Review of Systems	Yes	No		Yes	No		Yes	No
Ear ringing			Change in vision			Chest Pain		
Fatigue			Cough			Wheezing		
Loss of appetite			Nosebleeds			Shortness of breath		
Night sweats			Decrease smell			Nausea/Vomiting		
Weight loss			Nasal congestion			Heartburn or reflux		
Seasonal allergies			Postnasal drip			Sensation/something in throat		
Facial pressure			Runny nose			Easy bleeding		
Headaches			Snoring			Rash or hives		
Dizziness			Mouth sores			Numbness/ tingling		
Ear drainage			Problems swallowing			Migraine		
Ear Pain			Throat pain			Depression		
Ear Fullness			Voice Change					
Hearing loss			Enlarged lymph nodes					

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

Do you have Sleep Apnea? Y N Have you had a sleep study? Y N

If yes, date of Sleep Study: _____ Location: _____

Physician & Nurse Notes

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

Patient Name: _____ **DOB:** _____

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, 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 the office of J. Scott Robertson, M.D., P.C. has the right to change its Notice of Privacy Practices and I may contact the office to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that the office of J. Scott Robertson, M.D., P.C., restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that the office of J. Scott Robertson, M.D., P.C., is not required to agree to my requested restrictions, but if the practice does 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 waving 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 Acknowledgements

I acknowledge that certain procedures my physician recommends 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 the billing department is available to go over any questions before any recommended procedure and I further understand that the office observes the following financial policies:

-A $50 charge will be billed for all no-show appointments.

-A $250 surgery deposit will be required at time of scheduling surgery and if I cancel 14 days prior to my surgery the deposit is nonrefundable.

- A $25.00 forms fee will be charged for any forms filled out by the office.

Patient or Guardian Signature: _____ Date: _____

Patient Contact Information

J. Scott Robertson, M.D., P.C. or any staff member has my permission to discuss my account and medical conditions which may included 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: _____

Patient or Guardian Signature: _____ Date: _____