Aultman Medical Group General Surgery
2600 Tuscarawas Street West, Suite 600
Canton, Ohio 44708
Telephone: 330-453-4300 Fax: 330-453-3617

Dean W. Borth, M.D. Nicholas B. Roberts, M.D.
Nicholas Bisconti, M.D. Steven M. Kelly, M.D. David Litvak, M.D.
Diplomates of the American Board of Surgery

REGISTRATION INFORMATION

(PLEASE PRINT)

Date: _____ Home/Cell Phone: _____

Patient: _____
Last Name First Name Middle Initial

Responsible Party (if a minor): _____

Street Address: _____

City: _____State:_____Zip:_____

Patient Email Address: _____

Sex: Male / Female Age: ___ Birthday: _____ Single / Married / Widowed / Separated / Divorced

Employed: Yes / No Full-time Student ___ Part-time Student ____ School Name:_____

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse (or other responsible party) Name:_____ DOB: _____

Business Name and Address: _____

Occupation: _____ Business Phone: _____

Who is responsible for this account: _____Relationship to Patient: _____

Patient's Social Security #: _____ Spouse's Social Security #:_____

Do you have Medical Insurance: Yes / No If yes…

Name of Primary Insurer: _____

Identification Number: _____ Group #_____

Name of Secondary Insurer: _____

Identification Number: _____ Group # _____

Is your condition related to employment (current or previous)? Yes / No
Is your condition related to an auto accident? Yes / No In which State? _____

Other accident: Yes / No Please describe: _____

_____

In case of emergency, who should be notified? _____
Name

Phone: _____ Relationship to Patient _____

PLEASE LIST OTHER DOCTORS YOU HAVE SEEN IN THE PAST FIVE (5) YEARS:

1) _____ City/State _____
(General Practitioner, Specialist, Other)

2) _____ City/State _____
(General Practitioner, Specialist, Other)

3) _____ City/State _____
(General Practitioner, Specialist, Other)

Reason for seeing: _____

How did you learn of our practice? _____

Whom may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
(Name of insurance company)
and assign directly to **Aultman Medical Group General Surgery** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronically.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Aultman Medical Group General Surgery** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

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Name and Address of Physician Sending Records:

_____

_____

_____

I hereby request the release of my medical records to **Drs. Borth/Kelly/Roberts/Bisconti/Litvak** at the address shown above.

_____ _____
Signature of patient/parent/guardian Date

_____
Print name of patient

_____
Birthday Social Security

TO AVOID DELAYS WITH MAILING, YOU MAY FAX THE RECORDS TO: 330-453-3617

THANK YOU

Please Circle What Applies:	Yes	No	Please List Any Allergies & Reaction to Medicines, Food, and/or Environment		
Angina/Chest Pain					
Heart Attack/Stent					
Congestive Heart Failure					
Hypertension/High Cholesterol					
Irregular Heart Beat					
Pacemaker/Internal Defibrillator			**Please List All Medications (prescribed, over the counter, vitamin, herbal**		
Murmur/Mitral Value Prolapse			[ ] Medication List is Attached		
Peripheral Vascular Disease			Medication	Dose	Frequency
Blood Clot/Pulmonary Embolus					
Asthma/Emphysema/Home Oxygen					
Chronic Cough/Frequent Bronchitis					
Recent Cold/Flu					
Pneumonia/TB					
Short of Breath at Rest					
Short of Breath One Flight of Steps					
Sleep Apnea/CPAP/BiPAP					
Do you Snore?					
Are you often tired during the day?					
Do you stop breathing when you sleep?					
Heartburn/Esophageal Reflux					
Hepatitis/Yellow Jaundice					
Hiatal Hernia			**Blood Thinners:**		
Stomach Ulcer			**Please List Any Previous Surgeries/Medical Admissions**		
Kidney Failure/Dialysis					
Enlarged Prostate					
Kidney Stones			**Family History/Medical Problems:**		
Urinary Tract Infection			Mother:		
Frequent Headaches/Migraine			Father:		
Numbness/Tingling/Weakness			Siblings:		
Seizure			Other:		
Stroke/TIA					
VP Shunt			**Anesthesia Issues** [] None [] Nausea/Vomiting [] Other		
Arthritis/Fibromyalgia			**Reproductive History**: Times Pregnant Live Births		
Back Pain/Injury			**Smoking HX** []No []Yes [ ]packs/day [ ] years. Stopped [ ]years		
Glaucoma/Macular Degeneration			**Alcohol:** [ ] No [ ] Yes		
Retinal Detachment/Cataracts			**Other Drug Use**: [ ] No [ ] Yes		
Cancer			**Dentures**: []Upper []Lower Partials: []Upper [] Lower		
Chemotherapy/Radiation Therapy			Missing, Loose, chipped teeth: [ ] No [ ] Yes		
Depression			**Glasses:** [ ] No [ ] Yes **Contacts:** [ ] No [ ] Yes		
Bipolar			Date of most recent mammogram:		
Anemia			Date of most recent Colonoscopy:		
Bleeding Disorder			Date Influenza Vaccination: Date Pneumonia Vaccination:		
Sickle Cell Anemia			My Primary Care Physician is:		
Diabetes					
Insulin Pump			Home Phone Number: «PHTele»		
Hypo/Hyperthyroid			Cell Phone Number:		
HIV					
Isolation for Infection			**Print Name: «PName»**		
MRSA			**Date of Birth: «PDOB»**		
VRE			**Signature:** **Date:**		
Other, Explain:					