Angelo J. Mattalino, M.D.

Patient Registration Form

4765 S Lakeshore Dr
Tempe, AZ 85282
Ph: (480) 763 5950
Fax: (480) 763 1375

Today's Date: PCP:

PATIENT INFORMATION

Last name: First: Middle:

Is this your legal name? Yes ☐ No ☐ | if not, what is your legal name? | Former name: | Date of Birth: | Age: | Sex: ☐M ☐F

Address:

Social Security#: | Home phone no.: | Cell phone no.:

Occupation: | Employer: | Employer phone no.:

Other family members seen here: ☐Yes ☐No

How did you hear about us?

INSURANCE INFORMATION

(Please send us a copy of your insurance card (front and back) and your photo ID)

Person responsible for bill: | Date of Birth: | Address (if different): | Home phone #:

Is this person a patient here? ☐Yes ☐No

Occupation: | Employer: | Employer address: | Employer phone#:

Primary Insurance Name:

Subscriber's name: | Date of Birth of subscriber: | Group#: | Policy#:

Patient's relationship to subscriber:

Name of secondary insurance | Subscriber's name: | Group no#: | Policy#:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone#: | Work phone #:

The above information is true to the best of my knowledge. I understand that Dr Mattalino is an **Out-Of- Network provider.** I authorize my **out-of-network insurance benefits** to be paid directly to the physician. I understand that I am financially responsible for any balance. In the event of default, I promise to pay collection cost and reasonable fees as may be required to collect the unpaid balance on my account. I also authorize Orthopaedic Regenerative Medicine or insurance company to release any information require to process my claims.

I understand that I am responsible to know which outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialist appointments. If prior authorizations are required by my insurance for diagnostic testing and specialist appointments, I realized that it is my responsibility to request a referral authorization from my primary care provider. Failure to do so may result in my insurance company denying payments for services and I will be responsible for the services performed.

I authorize my insurance company to pay all benefits directly to Orthopaedic Regenerative Medicine and thereby agree to the release of relevant medical information to insurance carriers.

Patient/Guardian signature (electronic) Date

Angelo J. Mattalino, M.D.

Patient Authorization Forms

Authorization for Medial Treatment (Under 18)

This release and consent gives Orthopaedic Regenerative Medicine, permission to administer medical treatment to my child. I understand that every effort will be made to contact me. However, in case of an emergency, if I cannot be reached, I hereby give Orthopaedic Regenerative Medicine permission to act on my behalf in providing medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I release Orthopaedic Regenerative Medicine and all medical providers from liability in acting on my behalf in this regard in rendering such medical treatment.

Patient/Guardian signature (electronic) Date

Release of Medication History Authorization

I give Orthopaedic Regenerative Medicine permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed/ divulged as part of my medical record release.

Patient/Guardian signature (electronic) Date

No Show Cancellation and Surgical Coverage Responsibility Disclaimer

No show: I understand that a **$25.00** fee will be charged to my account if I neglect to cancel my appointment 24 hours prior to my schedule appointment.

Surgical Cancellation Fee: I understand that any surgical procedure must be canceled NO LATER than 7 calendar days prior to the Date of Surgery or an administrative charge of $100 will be assessed to my account.

Patient/Guardian signature (electronic) Date

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices. I understand that Orthopaedic Regenerative Medicine may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request. I give that Orthopaedic Regenerative Medicine permission to leave a message on my answering machine or with the following family members regarding reports, or blood work if I am not home when they call. I consent to general treatment, medical procedures, and medications prescribed by Orthopaedic Regenerative Medicine.

___ Copy given to patient ___ Patient declined copy

Patient/Guardian/Personal Representative signature Date

I give permission to disclosure protected health information from my health records, including financial information to the following:

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Patient/Guardian/Personal Representative signature (electronic) Date

Angelo J. Mattalino, M.D.

Patient Name: _____ DOB: _____ Age: ____ ☐ Male ☐ Female

Primary Care Physician: _____ Phone#: _____

Pharmacy: _____ Phone#: _____ _

Daily Medications: *(please include pain medication, herbal supplements, vitamins, and OTC}*

Name	**Dosage/Strength**	**Times/Day**

Weight: ____ _ Height: ____ _

Doyou have any known allergies? ☐ Yes ☐ No *Please list below:* Latex Allergy: ☐ Yes ☐ No

Allergy	Reaction	**Allergy**	**Reaction**

PAST MEDICAL HISTORY: Have you ever had any of the following? *(Check all that apply)*

☐ AIDS/HIV
☐ AnemiaStroke
☐ Blood clots
☐ Blood thinner

☐ History of heart condition(s)
☐ ·Hypertension (HBP)
☐ Hepatitis
☐ Diabetes: ☐ Type I ☐ Type II
☐ Controlled

☐ Kidney disease
☐ Sleep apnea
☐ Ulcer/ stomach problems
☐ Cancer: (type)_____
☐ Other: _____

Notes: _____ _

SURGICAL HISTORY: *(please include history for knees, shoulders, and elbows)*

Laterality_	Injury	**Surgeon**	**Date**	**City**	**State**
☐ Lt ☐ Rt.					
☐ Lt ☐ Rt.					
☐ Lt ☐ Rt.					

FAMILY HISTORY: Have any of your blood relatives had any of the following? *(Check all that apply)*

☐ Diabetes
☐ Hypertension(HBP)
☐ Rheumatoid Arthritis

☐ Heart Disease
☐ Cancer: (type)_____
☐ Other:_____

☐ None

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Do you use tobacco? ☐ Yes ☐ No If so, how many packs a day? _____

Occupation: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Sporting activities_____

Dominant Hand: ☐ Right ☐ Left

If female, are you pregnant? ☐ Yes ☐ No

Review of Symptoms: {check all that apply}

Constitutional Symptoms:

- ☐ Fever
- ☐ Night Sweats
- ☐ Weight gain _____lbs
- ☐ Weight loss _____lbs
- ☐ Exercise intolerance

Eyes:

- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Ears:

- ☐ Difficulty Hearing
- ☐ Ear Pain

Nose:

- ☐ Frequent Nosebleeds
- ☐ Nose/ Sinus Problems

Throat/ Mouth:

- ☐ Sore Throat
- ☐ Bleeding Gums
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Oral Abnormalities
- ☐ Mouth Breather
- ☐ Mouth Ulcer
- ☐ Teeth Abnormalities

Endocrine:

- ☐ Fatigue
- ☐ Increase Thirst
- ☐ Hair loss
- ☐ Increased Hair Growth
- ☐ Cold Intolerance

Cardiovascular:

- ☐ Chest Pain on Exertion
- ☐ Arm Pain on Exertion
- ☐ Shortness of Breath (walking)
- ☐ Shortness of Breath (lying)
- ☐ Palpation (known health)
- ☐ Murmur
- ☐ Lightheaded on standing

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Sleep Apnea

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Change in Appetite
- ☐ Black or Tarry Stools
- ☐ Frequent Diarrhea
- ☐ Vomiting Blood

Genitourinary:

- ☐ Urinary Loss of Control
- ☐ Difficulty Urinating
- ☐ Urinary Frequency
- ☐ Hematuria (Blood in Urine)
- ☐ Incomplete Emptying

Hematologic/ Lymphatic:

- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Excessive Bleeding

Musculoskeletal:

- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Joint Pain
- ☐ Back Pain

Integumentary (Skin):

- ☐ Abnormal Mole
- ☐ Jaundice
- ☐ Eczema
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ Growth/ Lesion

Neurologic:

- ☐ Loss of Consciousness
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Frequent/ Severe
- ☐ Headaches
- ☐ Migraines
- ☐ Restless Leg

Psychiatric:

- ☐ Depression
- ☐ Mania
- ☐ Sleep Disturbances
- ☐ Restless Sleep
- ☐ Feeling Unsafe in
- ☐ Relationship
- ☐ Alcohol Abuse

Chief Complaint

New Patient New Injury (FORMER PATIENT)

What injury are you being seen for today? ◯ Right ◯ Left ◯ Knee ◯ shoulder ◯ Elbow ◯ Other

Height: _____ _ Weight: _____ _

Pleas check one: ☐ Injury ☐ Re-Injury ☐ Sports Injury ☐ Work Comp ☐ Auto Accident
☐ No-Injury *(onset was* ◯ Gradual ◯ Sudden) - Date/onset of Injury? _ _ _ _ _ _ _

Please explain how injury/pain occurred:

_____

_____

_____

Were you seen in the E.R. / Urgent Care? ◯ Y e s ◯ No Where?_____ Date: _ _ _ _ _

On a scale from 0-10, how severe is your pain? _ _ _ _ _ _ _

Is the Pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

Does the pain occur... ☐ **Contantly** ☐ **Intermittently (comes and goes)** ☐ At night

Do you have any of the following? (Check all that apply)

◯ **Swelling** ◯ **Bruising** ◯ **Numbness** ◯ **Tingling** ◯ **Weakness** ◯ **Locking** ◯ **Giving way** ◯ catching

What makes your symptoms worse? (Check all that apply)

◯ Standing ◯ Walknig ◯ Exercise ◯ Twisting ◯ Kneeling ◯ Squatting ◯ Lying in Bed ◯ Sitting ◯ Stairs

What makes your symptoms better? ***{Check all that apply)***

◯ Rest ◯ Elevation ◯ Ice ◯ Heat ◯ Other_____

Have you had any of the following treatments? ***{Check all that apply)***

☐ Physical Therapy ☐ X-Ray(s) ☐ MRI(s) ☐ Injection(s) ☐ Other:_____

Notes: *(Please include date for service(s) provided and whether treatment(s) was/were successful)*

_____

Current Work Status: ☐ Regular ☐ Light Duty ☐ Not Working ☐ Not Working *(due to this injury)*

If injury occurred at work, what was the date last worked?

Are you currently receiving or planning to apply for: ☐ Disability ☐ Workers Comp ☐ Unemployment

_____ _____

Patient/Guardian signature Date