Jonathan S. Hott, M.D., P.L.C.
9225 North 3rd Street, Suite 100, Phoenix, Arizona 85020

New Patient Registration Forms

LAST NAME: _____ FIRST: _____ M.I. ____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELL PHONE #: _____ MALE: _____ FEMALE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: MARRIED _____ SINGLE _____ DIVORCED ____ WIDOWED _____

EMPLOYER NAME AND ADDRESS: _____
_____

WHO IS YOUR PRIMARY CARE PROVIDER?: _____
REFERRING PROVIDER: _____

In case of emergency please contact:

NAME: _____
ADDRESS: _____
_____
PHONE: _____ RELATIONSHIP TO YOU: _____

DOES YOUR VISIT TODAY RELATE TO A WORK INJURY? _____

MOTORVEHICLE ACCIDENT? _____ OTHER ACCIDENT?: _____
IF YES, PLEASE PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF YOUR ATTORNEY:_____
_____

Please bring completed forms with you at the time of your visit

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] other: _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____Date: ____/____/_____

Witness:_____ Date: ___/____/_____

I AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF BENEFITS TO DR. JONATHAN S. HOTT, 9225 N. 3RD ST., STE. 100, PHOENIX, ARIZONA 85020.

SIGNATURE:_____ DATE: _____

GUARDIAN: _____ DATE: _____

PRIVACY POLICY FOR
JONATHAN S. HOTT, M.D., P.L.C.

Healthcare is using computers and other electronic systems to process communications, claims, and payment processes. Privacy standards were developed to protect and secure your personal, financial, and health information. This notice of privacy briefly lists how information known by the healthcare provider can be used and disclosed.

How medical information will be routinely used and disclosed:

- For treatment
- For Payment
- For healthcare operations
- For victims of abuse, neglect or domestic violence
- For workers compensation
- For law enforcement

Your rights regarding your medical information, you can:

- Review or copy your records
- Request an amendment to your records
- Request restrictions
- Request confidential communications

Additional uses and disclosures of medical information:

- Research purposes
- As required by law, court orders
- For public health, public safety
- Government purposes, military, veterans
- In judicial proceedings

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602-943-4509

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices Acknowledgment but could not be obtained because:

___ Individual refused to sign
___Communications barriers prohibited obtaining the acknowledgment
___An emergency situation prevented us from obtaining acknowledgment
___Other Reason: _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA OR OTHER LEGAL AND ADMINSTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider, Jonathan S. Hott, PLC ("My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan.
- File appeals and grievances with the health plan.
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan.
- Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian of the patient if the patient is a minor).
- File appeals with your employer to compel the health plan administer to process claims correctly.
- To obtain copy of Plan Document and Summary Plan Description.

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plain; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This constitutes an express and knowing assignment of ERISA breach and/or fiduciary duty claims and other legal and/or administrative claims. I authorize communication with the Provider and is authorized representatives by email and my email address is: _____@_____.
I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient: _____ Date: _____

Initial Patient Assessment

Today's Date: ___/___/___

Patient Information

Last Name: _____ **First Name:** _____

Primary Phone: _____

Secondary Phone: _____

E-Mail: _____

Date of Birth: ___/___/___ **Age:** ____

Gender: M / F **Height:** _____ **Weight:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

How did you hear about us?

Referring Doctor:

PCP (leave blank if same as Referring Doctor):

Your Symptoms, Previous Tests, & Treatments

What problem or issue brings you in today?

☐ Back Pain ☐ Neck Pain

☐ Other:

When did it start, and what were you doing when it started (i.e., working, fall, accident)?

The pain occurred: ☐ All of a sudden ☐ Slowly

Was there an injury? ☐ Yes ☐ No

If yes, describe:

What is the timing of your pain? Check all that apply:

☐ Constant ☐ Comes & Goes

☐ Getting Worse ☐ Getting Better

☐ Not changing/staying about the same

Does the pain shoot down the arm or leg? ☐ Yes ☐ No

If yes, describe:

Describe your pain in words (select all that apply):

☐ Sharp ☐ Dull ☐ Achy

☐ Burning ☐ Stabbing ☐ Numbness

☐ Tingling ☐ Pulling ☐ Cramping ☐ Tightness

What makes your pain worse (i.e., sitting, standing, lifting)?

What makes your pain better (i.e., rest, ice, heat, pills)?

Do you have numbness or tingling? ☐ Yes ☐ No

If yes, where?

Do you have any weakness (arm/leg)? ☐ Yes ☐ No

If yes, where?

Do you have trouble walking due to the pain? ☐ Yes ☐ No

Any bowel/bladder issues or groin numbness? ☐ Yes ☐ No

What diagnostic tests have you had for this?

☐ X-Ray ☐ MRI

☐ CT Scan ☐ Bone Scan

☐ EMG (electromyography)

What treatments have you had so far?

☐ Medications ☐ Physical Therapy

☐ Injections ☐ Chiropractic

☐ Psychological ☐ Acupuncture

Have you ever had back or neck surgery? ☐ Yes ☐ No

If yes, describe:

Is there a law suit pending due to your pain? ☐ Yes ☐ No

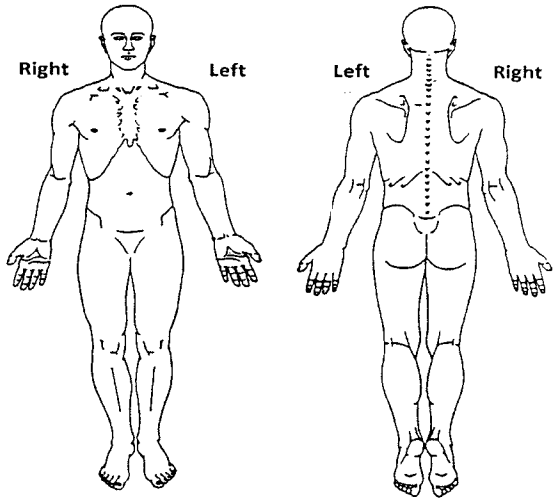
Your Pain

Please indicate on this line how severe your pain is:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain Possible**

Please draw where your pain is:



Does your pain affect your ability to work? ☐ Yes ☐ No

If yes, describe:

If you are not working due to your pain, how long have you been off of work?

Medications

Please list ALL of your medications with doses and frequencies, including supplements:

Past Medical History

Please list ALL of your **medical conditions** (i.e., high blood pressure, high cholesterol, diabetes, thyroid disease, heart disease, etc.) AND **surgeries** that you have had:

Please list any **allergies** including any reactions to anesthesia:

Family History

Your mother is: LIVING or DECEASED
Your father is: LIVING or DECEASED

Indicate which family members (if any) have/had these medical issues (example: writing "brother" next to diabetes):

Cancer	Heart Problems	Stroke
Diabetes	High Blood Pressure	Arthritis
Epilepsy	AIDS/HIV	Bleeding disorders
Hepatitis	Back/neck problems	Migraines
Muscle diseases	Nerve diseases	Psych problems
Stomach problems		Thyroid problems
Other:		

Social History

Do you use tobacco?	No	Yes (how much?)
Illicit drug use?	No	Yes (which drugs?)
History of drug abuse?	No	Yes (describe)
Do you drink alcohol?	No	Yes (drinks per week?)

Do you use an assistive device (cane / walker / wheelchair)?

How many falls have you had in the last 12 months?

None One, WITH injury One, WITHOUT injury
2+, WITH injury 2+, WITHOUT injury

Current Work Status (please circle):
Full-time / Part-time / Off-duty due to injury / Parent / Not working
Retired / Off-duty for other reason

If off-duty, when was the last time you worked?

Occupation and Employer:

Review of Systems

Recently, have you had any of these symptoms (please circle)?

Fevers/Chills	Weight Loss
Chest Pain	Shortness of Breath
Worse Pain at Night	Night Sweats
Vision Changes	Black Stools
Bloody Stools	Rash
Dizziness	Suicidal Thoughts

Important Activities

Please **list three important activities** that you are unable to do or that you are having difficulty doing as a result of your problems with **zero (0)** being **unable to perform** the activity and **ten (10)** being **able to perform** the activity at your pre-injury level:

1) _____

0 1 2 3 4 5 6 7 8 9 10

2) _____

0 1 2 3 4 5 6 7 8 9 10

3) _____

0 1 2 3 4 5 6 7 8 9 10

Follow up Assessment

As part of our commitment to improve health care, we are collecting data on our patients using a secure website (your personal information is always protected). Is it ok if a link to an assessment related to your care here is emailed to you? ☐ Yes ☐ No

Emergency Contact

My emergency contact is:

Relationship:

Phone Number:

Office Use Only

Evaluation Date:

Provider:
Jonathan S. Hott, MD Other: