Tulane University Hospital & Clinic

1415 TULANE AVENUE NEW ORLEANS, LOUISIANA 70112

PRE REGISTRATION

Date _____ Medical Record No. _____ Physician _____

Patient's Name _____
last first middle maiden

Address _____
number, street, apt. city, state zip code

Parish or County _____ Patient's Home Phone (_____) _____
area code

Date of Birth _____ Patient's Age _____ Patient's Soc. Sec. No. _____

Patient's Sex _____ Marital Status _____ Race _____

Patient's Religion _____ Patient's Employer _____

Patient's Employer's Address _____
number, street city, state zip code

Patient's Business Phone (_____) _____ Patient's Occupation _____
area code

Employment Status _____ ☐ _____ full time _____ ☐ _____ part time _____ retired date _____ ☐ _____ self-employed

Referring Physician _____ Phone _____

Address _____

GUARANTOR:(Person Responsible for Bill)

Name _____ Soc.Sec. No. _____

Address _____

Home Phone (_____) _____ Date of Birth _____ Sex _____ Relationship _____
area code

Employer _____ Address _____

_____ Business Phone (_____) _____
city, state zip code area code

Occupation _____ Date or Length of employment _____

Employment Status _____ full time _____ part time _____ retired date _____ self-employed

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NEXT OF KIN:

Name _____ Soc. Sec. No. _____ Home Phone (_____) _____
area code

Address _____ Date of Birth _____
number, street, apt. city, state zip code

Relationship _____ Employer _____

Employer's Address _____ Business Phone (_____) _____
area code

Occupation _____ Emp. Status _____ full time _____ part time _____ retired _____ self-employed

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ALTERNATE CONTACT:

In case of emergency, please notify: Name _____

Phone (_____) _____ Relationship _____
area code

87-510 (4-96)

INSURANCE INFORMATION

MEDICARE # _____

MEDICAID # _____

PRIMARY INSURANCE CARRIER

Insurance Company's Name _____ Address _____

Phone Number _____ is this through your employment? Yes ☐ No ☐

If so, what is the employers name _____ Phone _____

Employee ID # _____ Group Name _____

Contact or Individual # _____ Group # _____

Policyholder's Name _____ Relationship to patient _____

SECONDARY INSURANCE CARRIER

Insurance company's Name _____ Address _____

Phone Number _____ is this through your employment? Yes ☐ No ☐

If so, what is the employers name _____ Phone _____

Employee ID # _____ Group Name _____

Contact or Individual # _____ Group # _____

Policyholder's Name _____ Relationship to patient _____

WORKMAN'S COMPENSATION / THIRD PARTY BILLING

Name _____

Address _____

Phone No.(_____) _____ Ext _____

Confirmed By _____ Title _____ Date _____

MEDICARE ELIGIBILITY DETERMINATION

Part I. WORKMAN'S COMPENSATION

a. Was your illness or injury due to a work related accident/condition? Yes ☐ No ☐

b. Is your condition covered by a Workmen's Compensation plan or the Federal Black Lung Program? Yes ☐ No ☐

Part II. ACCIDENT

a. Was your illness/injury due to an accident? Yes ☐ No ☐

Part III. ESRD/KIDNEY DIALYSIS

a. Are you age 65 or over? Yes ☐ No ☐

b. Are you undergoing kidney dialysis for ESRD? Yes ☐ No ☐

Part IV. DISABILITY

a. Are you a disabled Medicare beneficiary under age 65? Yes ☐ No ☐

Part V. EMPLOYER'S GROUP HEALTH PLAN

a. Are you or your spouse employed and participating in the Employer's Group Health Plan? Yes ☐ No ☐

MEDICARE ELIGIBILITY: MEDICARE PRIMARY ☐ SECONDARY ☐

Patient Signature _____ Date: _____

Interview by _____

Date:_____

Chief Compliant:_____Location: ☐ Left ☐ Right

Date Injury/accident occurred:_____

How did injury/accident occur:_____

_____

Do you wear glasses? ☐ Yes ☐ No Contacts? ☐ Yes ☐ No

Drug Allergies or Adverse effects?_____

_____

Current Medications please include over the counter:

Medication	Dose	Frequency	Medication	Dose	Frequency

Past Surgeries please list in chronological order:

Year	Surgery

Family History Please list medical illness affecting immediate family i.e. parents & siblings:

Disease	Family Member	Disease	Family Member

Social History please check all that apply:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Alcohol use: ☐ Occasional ☐ Daily ☐ Heavy ☐ None

Tobacco use: ☐ No ☐ Yes If yes, Number of Years _____ Pack/day _____

Drug use: ☐ No ☐ Yes

Tulane UNIVERSITY HOSPITAL & CLINIC

TISM PATIENT HISTORY

Patient Name: _____

M.R. # _____

88-265 (3/05)

General History please check all that apply:

General:
- ☐ Weight Change
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Urinary Frequency
- ☐ Bleeding
- ☐ Lumps or Masses
- ☐ Dizziness or Fainting
- ☐ Itching or Rash
- ☐ Diabetes Mellitus
- ☐ Thyroid Problems
- ☐ Cancer

Ear-Eye-Nose-Throat:
- ☐ Vision Change
- ☐ Hearing Change
- ☐ Tinnitus (ringing in ears)
- ☐ Dentures
- ☐ Bleeding Gums
- ☐ Hoarseness

Gastrointestinal:
- ☐ Cough/sputum
- ☐ Nausea and vomiting
- ☐ Jaundice
- ☐ Hepatitis

Cardiovascular:
- ☐ Heart disease/chest pain
- ☐ Hypertension (high blood pressure)
- ☐ Mitral Valve Prolapse
- ☐ Thrombophlebititis

Genitourinary:
- ☐ Urinary Tract Infections
- ☐ Incontinence
- ☐ Veneral Disease
- ☐ Menopause

Neurological:
- ☐ Seizures
- ☐ Paralysis
- ☐ Numbness
- ☐ Weakness

Musculoskeletal:
- ☐ Backaches
- ☐ Joint Pain
- ☐ Joint Swelling

Breast:
- ☐ Lumps or Pain
- ☐ Nipple Discharge

Respiratory:
- ☐ Dysphasia (difficulty swallowing)
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Pleurisy/pneumonia
- ☐ Asthma
- ☐ Shortness of Breath

List any coach/trainer or physician and address that you wish to receive a report:

Physician: _____

Physician: _____

Coach/trainer: _____

Tulane UNIVERSITY HOSPITAL & CLINIC

TISM PATIENT HISTORY

Patient Name: _____

M.R. # _____