ALBERT FRANCHI, M.D. - BOSTON PROLOTHERAPY

Patient Registration Information

PATIENT INFORMATION

First Name | M.I. | Last Name | Date of Birth | Age | Sex ❑ M ❑ F

Street Address | Apt. | City | State | Zip Code | Phone Numbers Home: ( ) - Cell: ( ) -

Email: | Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

How did you learn about our practice?

❑ WEEI 93.7 FM ❑ WBZ 1030 AM ❑ 98.5 FM The Sports Hub ❑ Facebook

❑ Previously Treated by Dr. Franchi ❑ Google/Internet ❑ Physician Referral

❑ From a Previous Patient ❑ Family/Friend Referral ❑ Other: _____

EMERGENGY CONTACT

First Name | M.I | Last Name | Relationship to Patient | Sex ❑ M ❑ F

Street Address | City | State | Zip Code | Phone Numbers Home: ( ) - Cell: ( ) -

PRIMARY INSURANCE INFORMATION

Insurance Name | Address | City | State | Zip Code

ID/Certificate Number | Group ID/Number | Employer/Company

Policy Holder (Subscriber) Name | Subscriber Birthdate | Subscriber Sex ❑ M ❑ F

SECONDARY INSURANCE INFORMATION

Insurance Name | Address | City | State | Zip Code

ID/Certificate Number | Group ID/Number | Employer/Company

Policy Holder (Subscriber) Name | Subscriber Birth Date | Subscriber Sex ❑ M ❑ F

REFERRED TO THIS PRACTICE BY

Primary Care Physician | Phone Number ( ) -

I hereby give lifetime authorization for payment of insurance benefits to be made directly to ALBERT FRANCHI, M.D., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. **Your initial office consultation with the doctor will be billed directly to your insurance carrier. Prolotherapy is not a covered service under Medicare or insurance plans, and physicians are therefore not allowed to bill insurance companies for the Prolotherapy injections. Patients must pay for Prolotherapy injections directly.** In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that no guarantees have been made to me regarding the outcome of this care. I agree a photocopy of this agreement shall be valid as the original.

Date: _____ Signature: _____

ALBERT FRANCHI, M.D. BOSTON PROLOTHERAPY PATIENT HISTORY

Last Name: _____ First Name: _____ Middle: _____

Chief Complaint: _____ **LEFT / RIGHT / BILATERAL**

How & where it happened? _____ Date of Onset: _____

Have you had X-rays? _____ an MRI? _____ If yes, when and where were they done? _____

Have you had a problem like this before? ❑ Yes (When?) _____ ❑ No

PAST MEDICAL HISTORY: HAVE YOU EVER HAD?

	Yes	No	Don't Know		Yes	No	Don't Know
Anemia	❑	❑	❑	Heart attack	❑	❑	❑
Arthritis	❑	❑	❑	Heart Failure	❑	❑	❑
Asthma	❑	❑	❑	High Blood Pressure	❑	❑	❑
Cancer (location)	❑	❑	❑	Kidney Failure	❑	❑	❑
COPD	❑	❑	❑	Liver Disease	❑	❑	❑
Diabetes	❑	❑	❑	Osteoporosis	❑	❑	❑
Epilepsy	❑	❑	❑	Phlebitis	❑	❑	❑
Glaucoma	❑	❑	❑	Stomach Ulcers	❑	❑	❑
Gout	❑	❑	❑	Stroke	❑	❑	❑
Hemophilia	❑	❑	❑	Thyroid Trouble	❑	❑	❑
	❑	❑	❑		❑	❑	❑

LIST ANY PREVIOUS SURGERIES

Date	Surgical Procedure	Hospital
_____	_____	_____
_____	_____	_____

FAMILY HISTORY Indicate which family member next to the illness M=Mother, F=Father, S=Sibling, C=Child

	M	F	S	C
Arthritis				
Anxiety / Depression				
Cancer				
Diabetes				
Heart Disease				

	M	F	S	C
Hemophilia				
High Blood Pressure				
Kidney Disease				

	M	F	S	C
Liver Disease				
Other:				

SOCIAL HISTORY

❑Single ❑Partner ❑Married ❑Separated ❑Divorced ❑Widowed How many people live with you? _____

Currently working /volunteering? ❑Yes ❑No ❑Retired ❑Student ❑Disabled Occupation: _____

Do you use Tobacco Products? ❑Yes ❑No ___ # packs per day Alcohol Use? ❑ None ❑ Socially ❑ Daily ❑ Frequently

PATIENT NAME: _____ D.O.B. _____

REVIEW OF SYSTEMS: CIRCLE ANY CONDITION BELOW THAT YOU HAVE OR CHECK					NONE	Describe
M/S		Fracture	Which bone?	Back Pain	❑	
GI	Heartburn	Nausea	Vomiting	Blood in Stool	❑	
ENDO	Frequent Thirst	Frequent Urination		Always Hot or Cold	❑	
CONST	Weight Loss	Frequent Fever		Loss of appetite	❑	
EYE	Blurred Vision	Double Vision		Vision loss	❑	
ENT	Hearing Loss	Hoarseness		Trouble swallowing	❑	
C-VASC	Chest Pain	Palpitations			❑	
RESP	Chronic Cough	Shortness of Breath			❑	
GU	Painful Urination	Blood in Urine			❑	
SKIN	Frequent Rashes	Skin Ulcers		Psoriasis	❑	
NEURO	Headaches	Dizziness			❑	
PSYCH	Drug /Alcohol Problem	Depression			❑	
HEME	Easy Bleeding	HIV/ AIDS			❑	

MEDICATIONS

❑ I do not take any medications

LIST ALL YOUR MEDICATIONS BELOW INCLUDING VITAMIN OR HERBAL SUPPLEMENTS.

l. Atenolol _____	6. Coumadin _____	11. Insulin _____	16. Naproxen _____	21. Simvastatin _____
2. Allopurinol_____	7. Flexeril _____	12. Levoxyl _____	17. Paxil _____	22. Synthroid _____
3. Aspirin 81 mg____	8. Fosamax _____	13. Lipitor _____	18. Percocet _____	23. Vicodin_____
4. Celexa _____	9. Glucophage ____	14. Lisinopril _____	19. Prilosec _____	24. Xanax _____
5. Crestor _____	10. HCTZ_____	15. Metformin ____	20. Procardia _____	

Other: _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? PLEASE LIST ❑ I do not have any allergies

Name /Address of Preferred Pharmacy: _____

MEDICATION / NARCOTICS POLICY

You must take your medication only as prescribed. Supplementation. early refilling of your prescription, requesting prescriptions from any other physician or practice, prescriptions taken from family or friends, overuse or abuse of medications subjects you to immediate dismissal from the practice. If you are to have a prescription refilled from our office, you may need to make an appointment during standard business hours. Prescriptions will not be filled outside of normal business hours.

****

This is to certify that I, the undersigned (1) Consent to the administration upon the patient named above, such medications and treatments as may be considered necessary or advisable, (2) Authorize the release of any information from this record as required by my attorney, an insurance company or other reimbursing agency, (3) am responsible for obtaining any referrals and/ or pre-authorizations that may be required by my insurance company (4) Authorize payment directly to Albert Franchi, M.D any benefits otherwise payable to me for services rendered (5) have read and understand the MEDICATION/ NARCOTICS POLICY. I understand that I am financially responsible for any charges not covered by this authorization.

_____	_____	_____	_____	_____
SIGNATURE	RELATIONSHIP	DATE	WITNESS	PHYSICIAN'S INITIALS / DATE