# 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 _____

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**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. # _____