

Lawrence O'Holleran, PC
Registration Information

Please Print

Date of Appointment: _____

Home Phone: (____) _____

Cell Phone: (____) _____

I do hereby give permission to this office, its successors and assigns to call any cell phones owned or utilized by me. Yes No

Last Name: _____ First: _____ Middle: _____

Preferred first name: _____ Responsible Party (if a minor): _____

Street address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ Patient social security: _____

Race or Ethnicity: ☐ Caucasian ☐ Hispanic or Latino ☐ Asian ☐ African American ☐ American Indian ☐ Other ☐ Decline
☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Purpose of visit: _____

Employer: _____ Employer phone number: (____) _____

Who is responsible for this account? _____ Relationship: _____

What is your **preferred pharmacy**? _____

INSURANCE COVERAGE – PRIMARY:

Insurance Co Name: _____ Policy # _____

Name of Policy Holder (Insured) _____ Policy Holder's DOB _____ / _____ / _____

Policy Holder's SSN: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child

INSURANCE COVERAGE – SECONDARY:

Insurance Co Name: _____ Policy # _____

Name of Policy Holder (Insured) _____ Policy Holder's DOB _____ / _____ / _____

Policy Holder's SSN: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child

Worker's Compensation Claim #: _____ Date of Injury: _____

In case of emergency contact: _____ Phone (____) _____ Relationship: _____
_____ Phone (____) _____ Relationship: _____

I certify that I, and/ or my dependent(s) have insurance coverage with the above-named company(ies) and assign directly to Dr. Lawrence O'Holleran all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian, or Personal representative

Relationship to Patient

Lawrence W. O'Holleran, PC

Authorization to Release Medical Records/Information

I hereby authorize Lawrence O'Holleran PC to speak to the individual(s) named below regarding my care, my test results and my bill:

_____	_____
Name	Relationship
_____	_____
Name	Relationship

Privacy Practices Acknowledgement

I acknowledge this notice of Privacy Practices which is displayed at the clinic of Lawrence O'Holleran, PC and I have had the opportunity to review it. I can obtain a copy of the Privacy Practices by requesting one from the clinic of Lawrence O'Holleran, PC.

Patient Financial Responsibility Statement

- It is the patient or guardian responsibility to be aware of your insurance coverage, policies and any exclusions or limitations as well as any authorization requirements. Please contact your insurance to obtain your benefits prior to your surgery.
- We will notify your insurance of the scheduled procedure and bill your insurance for you; however, it is your responsibility to provide us with your most current updated insurance information. You will be responsible for the entire amount of charges if your insurance is not in effect at the time of service.
- Co-payments and co-insurance payments and deductible amounts are the patient or guardian responsibility. These amounts are due within 90 days from the receipt of billing unless other arrangements are made with our billing service.
- Every attempt is made to authorize your surgery with your insurance carrier prior to the procedure. You will be responsible for any services that Dr. O'Holleran believes are medically necessary based on the current standard of quality medical care and are later denied by your insurance.
- Your surgery may require an assistant surgeon and an anesthesiologist is required for all surgeries. The charges for these services are separate from Dr. O'Holleran and the Surgery Center. You will be responsible for these additional charges for your surgery.
- Self-pay procedures must be arranged prior to the actual surgery. Our office can assist you with arrangements; however, agreed upon amount must be paid in full prior to the surgery.
- In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney fees and such costs as the court deems proper.
- You will be responsible for payment of the following additional charges:
\$25.00 will be charged for checks returned for insufficient funds.

I have read the above statements and understand that regardless of insurance coverage, I am responsible for payment of this account. I agree to the terms of the Financial Responsibility as outlined above.

Name of Patient: _____

Signature of Patient/Parent/Guardian _____

Date: _____

Lawrence W. O'Holleran, PC
Patient Health History

Patient Name: _____ Age _____

Who is your Primary Care Provider? _____ Who referred you to our office? _____

Current weight _____ Height _____ Date of last Flu shot _____

Reason for your visit: _____

Allergies to any medication or substances: _____

Are you allergic to Latex products? _____

Current medications with dosages and how often you take the medication. Please include any over the counter vitamins, herbal or dietary supplements: _____

Significant current or past medical conditions or injuries: _____

Previous surgeries and dates of procedures: _____

Previous hospitalizations – date and reason for hospital stay: _____

Do you have a history of any of the following:

Blood clots? Yes No Date: _____ Location of clot: _____

Treatment: _____

Bleeding abnormalities: Yes No Explain: _____

Anesthesia Complications: Yes No Explain: _____

Do you use any of the following?

Type of product, how much and how often

Street Drugs Yes No _____

Tobacco Products Yes No _____

Started _____ Quit _____

Are you currently pregnant? If yes, estimated date of delivery: _____

Any other conditions or significant information needed to assist in your care not otherwise listed:

Family Medical History:

☐ Family history unknown

☐ Adopted

Relationship

Pertinent Medical History

Mother

Father

Sister

Brother

Other

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform Dr. O'Holleran of any changes to my health.

Signature of Patient/Parent/Guardian _____ Date: _____

FOR STAFF USE ONLY

BP _____ Pulse _____ Respirations _____ Temp _____

Lawrence W. O'Holleran, PC
Review of Systems

Patient Name: _____

Please mark the conditions that apply:

General

- | | | |
|---|--|--|
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Less interest in doing things |
| <input type="checkbox"/> Weight loss (amount _____) | <input type="checkbox"/> Cancer (type) _____ | |
| <input type="checkbox"/> Weight gain (amount _____) | <input type="checkbox"/> Diabetes | |

Eyes, Ears, Nose & Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Wear eyeglasses | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Eye infections | <input type="checkbox"/> Cataracts |

Lungs

- | | | |
|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough | <input type="checkbox"/> Emphysema/COPD |

Heart

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Blood clots |

Skin

- | | | |
|---------------------------------|--|----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Allergic reaction/hives | <input type="checkbox"/> Growths |
|---------------------------------|--|----------------------------------|

Urinary

- | | | |
|---|--|--|
| <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Frequency | <input type="checkbox"/> Change in urine force or flow |

Bones and Joint

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Weak bones | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Difficulty with ambulation | |

Neurologic/Psychiatric

- | | | |
|--|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Tremors/hands shaking | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Headaches (frequent) | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Anxiety |

Gastrointestinal

- | | | |
|---|--|---|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Trouble swallowing |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Trouble with spicy/fatty foods |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Bloating | <input type="checkbox"/> Abdominal pain after eating |

Additional information you feel is important: _____

