PATIENT REGISTRATION

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Orthopaedic Surgery
Pediatric Orthopaedic Surgery

First Name ______________ Last Name ______________ M.I. ______

PART 1 – PATIENT INFORMATION

Date of Birth:____/____/____ Age____ Marital Status: S□ M□ D□ W□
Sex: M□ F□ Social Security # ____/____/______
Address:____
Street City State Zip Code
Phone: (H)__________________)(C)__________________(W)__________________
Email: ______________________________Employer:______________________
*Race:__________________Language:________________Ethnicity:__________________
*Information required by US Dept. OF Disease Control and Prevention

Primary Care Physician____________________Address:______________________
Phone #______________________________
How were you referred to this office?______________________________
Part of body to be examined______________________________

RESPONSIBLE PARTY (GUARANTOR)

Name of Responsible Party:______________________Relationship to patient:____________
Address:____City:__________________
State:_____ Zip Code:____________ Phone:____________________
Date of Birth:______________________________ Social Security#:__________________

INSURANCE

Primary Insurance:____
Policy ID#:_________________________ Group#:______________________________
Subscriber's Name:____________________ Subscriber's Date of Birth:__________________
Relationship to Patient:________________ Subscriber's Social Security #:________________
Subscriber's Employer:____

Secondary Insurance:____
Policy ID#:_________________________ Group#:______________________________
Subscriber's Name:____________________ Subscriber's Date of Birth:__________________
Relationship to Patient:________________ Subscriber's Social Security #:________________
Subscriber's Employer:____

WORKER'S COMPENSATION/MOTOR VEHICLE/SCHOOL ACCIDENT INFORMATION

Please note if this is work or accident related.
□Work Injury □Motor Vehicle Accident □School Injury
Date of Injury:__________________________Body part involved:______________________
*Please complete the required Worker's Comp/No Fault forms in addition to this sheet.
*For School injuries please provide school insurance claim form

Medical History/Review of Systems Form

Patient's Name:______________________________ Today's Date:______________

Patient's Date of Birth:____________ Height:_______ Weight_____ Blood Pressure:_____

What are you being seen for today:____________________________ Circle: Left or Right

ALLERGIES:
List the name of any medication that you are allergic to and the reaction when you take it.

____

LATEX ALLERGY: Yes No

CONSTITUTIONAL SYMPTIONS:

Fever	Yes	No
Good general health	Yes	No
Headaches	Yes	No
Night Sweats	Yes	No
Recent weight change	Yes	No

CARDIOVASCULAR:

Chest pain or angina pectoris	Yes	No
Heart trouble	Yes	No
Palpitation	Yes	No
Swelling of feet, ankles, hands	Yes	No
Spitting up blood	Yes	No

MUSKULOSKELETAL:

Back pain	Yes	No
Difficulty in walking	Yes	No
Joint pain/stiffness or swelling	Yes	No
Muscle pain or cramps	Yes	No
Osteoporosis	Yes	No
Weakness of muscles or joints	Yes	No

NEUROLOGICAL:

Convulsions or seizures	Yes	No
Head injury	Yes	No
Light headed or dizzy	Yes	No
Numbness or tingling sensations	Yes	No
Stroke	Yes	No

GASTROINTESTINAL:

Abdominal pain or heartburn	Yes	No
Nausea or vomiting	Yes	No
Peptic ulcer (stomach or duodenal)	Yes	No

MEDICATIONS:
List the name, dose and frequency of all medications you are taking:______________________

____

MEDICAL HISTORY:

Acute infections	Yes	No
Anemia	Yes	No
Arthritis/Gout	Yes	No
Bleeding tendency	Yes	No
Blood transfusion	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Hearing	Yes	No
Hypertension	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Scoliosis	Yes	No
Thyroid disease	Yes	No

PSYCHIATRIC:

Depression	Yes	No
Memory loss/confusion	Yes	No
Mood change	Yes	No
Nervousness	Yes	No

RESPIRATORY:

Asthma or wheezing	Yes	No
Chronic or frequent coughs	Yes	No
Shortness of breath	Yes	No

Check all tests you have had in the past 4 months:

___Arteriogram ___Blood work ___Bone scan
___CT scan ___EMG ___Myelogram
___X-Ray ___MRI
Other:______________________________

PREVIOUS SURGERIES: Yes No
If Yes, Please list:______________________

SOCIAL HISTORY:

Alcohol use:		Tobacco use:		Drug use:	
_____Never	_____Rarely	_____Never	_____Rarely	_____Never	_____Rarely
_____Moderate	_____Daily	_____Moderate	_____Daily	_____Moderate	_____Daily

FAMILY HISTORY OF DISEASES OR MEDICAL CONDITIONS: ___Arthritis ___Asthma ___Bleeding disorder ___Cancer ___Diabetes ___Gout ___Hearing impaired ___Heart disease ___High blood pressure ___Kidney disease ___Liver disease ___Osteoporosis ___Scoliosis ___Stroke ___Thyroid disease ___Ulcers

If Yes to any of the above, please complete:

Relationship	Disease(s)	If deceased, please list age

PATIENT'S SIGNATURE:______________________
DATE:______________________

PHYSICIAN'S SIGNATURE:______________________
DATE:______________________

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ACKNOWLEDGEMENT FORM

PATIENT NAME________________________DATE OF BIRTH______________________

HIPAA/RELEASE

I__________________________, have received a copy of the Privacy Practices and authorize the release of any information concerning my (or my child's) examinations and/or treatment provided for the purpose of evaluating and processing of claims for insurance benefits.

______________________ ______________________
Signature of Patient/Guardian Date

PARTICIPATING AND NON-PARTICIPATING INSURANCE AGREEMENT

I__________________________, recognize and accept personal responsibility for any balance remaining after payment of insurance benefits. I understand that if payment is not made in a reasonable amount of time (three months) I may be charged interest and/or a collection fee. (Exception To Participating Insurance Company Agreements) I understand and accept that co-payments are due at the time of service and a $10.00 (ten dollar) surcharge will be applied for non-payment of copayment. I understand that if I am seen under my private insurance and then want to use Workers' Compensation or No Fault benefits there will be no back billing or refunding of copayments. I understand that if I am a private pay patient that payment is due at the time of service unless prior financial arrangements have been made with this office.

______________________ ______________________
Signature of Patient/Guardian Date

WORKERS' COMPENSATION/NO FAULT PATIENTS

I __________________________,recognize and accept that I must provide current and valid Workers' Compensation/No Fault billing information at the time of service. I understand that such information is to be provided at the time of service and that any missing information is to be provided within 3 days of treatment. In the event that the insurance carrier has closed or not accepted such claims I will be financially responsible for such charges.

______________________ ______________________
Signature of Patient/Guardian Date

DISCLOSURE TO FAMILY MEMBERS

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members listed below:
Name:____________________Relationship:__________________Contact Number:______________

CONSENT FOR HEALTHCARE COMMUNICATION

I give permission for the above named medical practice to leave Protected Health Information for test results, appointment reminders and/or other general information on my voicemail or answering machine.

____
Signature of Patient/Guardian