Patient Registration Form

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Patient Information

Date ____ First Name ____ Middle ____ Last Name ____

Age ____ Date of Birth ____ SS# ____

Student Status: ◯ Full-time student ◯ Part-time student

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married

Highest Grade Completed: ◯ Jr. High ◯ HS ◯ College

Street Address ____ Apt. # ____

City ____ State ____ Zip ____ Home Phone ____ Cell Phone ____

E-mail Address ____

Primary Care Physician ____ Phone # ____ Referring Physician ____

Okay to leave message at: ◯ Home ◯ Work ◯ Cell

Preferred Pharmacy/Address ____ Phone # ____

Employer Name/Address ____ Phone # ____

Do you have a living will?: ◯ Yes ◯ No

Executor/Legal Guardian/Custodian Information (If Applicable)

Name (First, Middle, Last) ____ Date of Birth ____

SS# ____ Relationship to Child/Minor ____

Street Address ____ City ____ State ____ Zip ____

Home Phone ____ Cell Phone ____ Employer's Name ____

Employer's Address ____ Employer's Phone ____

City ____ State ____ Zip ____

Emergency Contact Information

Name (First, Middle, Last) ____ Relationship to Patient ____

Street Address ____ City ____ State ____ Zip ____

Home Phone ____ Cell Phone ____

Employer's Name ____ Employer's Address ____

City ____ State ____ Zip ____ Employer's Phone ____

Billing Information

Patient Name:

Billing Name | Date of Birth | SS#

Street Address | City | State | Zip

Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Insurance Information

Primary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Primary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Secondary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Secondary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Consent to Treat/ Financial Agreement

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Welcome to ORTHOSOUTH. We are committed to the success of your medical treatment and care. Please understand, payment of your bill is part of this treatment and care. We accept most insurance policies, worker's compensation and self pay. If you're unsure whether we accept your policy, the best way to check is to call your insurance company. Their number is usually located on the back of your insurance card. All applicable co-pays and deductibles are paid at the time of service. Payment for co-insurance percentage, and any deductibles for the office visits, x-rays, DME supplies, injections and other charges, are paid at the time of service. Self pay is paid in full at time of service. If you have any questions feel free to ask our staff.

I consent to treatment at OrthoSouth and acknowledge it is my responsibility to provide OrthoSouth with correct billing and contact information. I consent to the payment of medical benefits to OrthoSouth and associated medical providers. I hereby authorize OrthoSouth to release any medical information to insurance companies and appropriate third parties as determined by OrthoSouth. A photocopy of this authorization is to be considered as a valid original until revoked by me in writing.

I recognize and understand payment is due at the time of service. I agree I am financially responsible for all charges made to my account, whether or not an insurance company, attorney or other third-party payer is involved with payment. Because of contractual obligations between OrthoSouth, my insurance company, and me; I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. I understand returned checks are subject to a $25 service charge. I agree to pay all costs of collecting unpaid balances, including but not limited to, legal fees, court costs and attorney's fees. I also understand, in the event my account is turned over to a third-party collection agency, I am financially responsible for any collection fees associated with the collection of monies owed on my personal account.

MEDICARE: I/we authorize Medicare to furnish OrthoSouth any information regarding my medicare claim under Title XVIII of the Social Security Act. I also request payment of authorized Medigap benefits be made on my behalf to OrthoSouth for any services furnished me by our physicians.

I understand and agree to the above information and financial responsibilities, and certify all information provided by me is true and accurate.

______________________________ ______________
Patient Name (Printed) Date

______________________________ ______________
Signature of Patient or Legal, Documented Guardian Date

Patient Health Information

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REVIEW OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

I acknowledge I have received a copy of OrthoSouth's Notice of Privacy Practices regarding privacy of personal health information.

____________________________________ ____________
Patient Signature Date

HIPAA PATIENT COMMUNICATIONS

It is the policy of this office not to release confidential medical information regarding the treatment of any patient without the express written authorization of patient, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If medical information is to be provided to other family members, friends, caretakers, etc., please list below. By signing below, you authorize OrthoSouth to release medical information to the parties provided to OrthoSouth at your discretion. Patient reserves the right to revoke authorization at any time. Personal health information may be subject to re-disclosure by recipient, and therefore may no longer be protected by this authorization. This authorization shall remain in effect until otherwise revised with a new release form.

I understand as part of my personal health care, OrthoSouth originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care and treatment.

With this consent, OrthoSouth may request any records pertaining to my medical history needed for further treatment. With this consent, OrthoSouth may e-mail or call my home or other designated location and leave a message on voice mail or in person in reference to any items and any call pertaining to my clinical care, including laboratory results among others. With this consent, OrthoSouth may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders and other correspondence, as long as they are marked Personal and Confidential.
I have the right to restrict how Orthosouth uses or discloses my personal health information to carry out treatment, payment, or healthcare operations. However, the practice is not required to agree to my requested restrictions; but if it does, it is bound by this agreement. By signing this form, I authorize OrthoSouth to use and disclose my protected health information to carry out my treatment, payment, or health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I authorize OrthoSouth to speak to the following parties regarding my personal health care:

Name		Name	
Name		Name	
Name		Name	

____
Patient Printed Name

____________________________________ ____________
Patient Signature Date

Health Information Access

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OrthoSouth Patient Portal Access Registration

WHAT IS A PATIENT PORTAL?

OrthoSouth is pleased to offer a private and secure portal for patients to keep current with their medical records, reports and updates. Patients may gain access to OrthoSouth's secure patient portal by providing a valid e-mail address upon registering for your first appointment, our updating your current record.

The ***Patient Portal*** provides a platform where OrthoSouth physicians and clinical staff can quickly publish medical information for your review online. The portal also provides:

- A secure messaging system that facilitates communication between practice and patient.

- A practice landing page for log-in.

- Secure access to view personal medical records. Records are available as a data file (in XML format), which you can download and provide to other practices or upload to a personal heath record (such as Microsoft HealthVault), or as a human readable report (in HTML or PDF format), which you can review at your leisure.

Upon adding a valid e-mail address to your current record, OrthoSouth staff members will register you for the portal, at which time you'll receive an e-mail with a link to the patient portal, and log-in information.

I authorize OrthoSouth to register me for the patient portal.

E-mail address: ____________________

____
Patient Printed Name

____________________ ____________
Patient Signature Date

New Patient History

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Patient Information

Date

First Name | Middle Name | Last Name

Patient Age | Date of Birth | Height | Weight | ◯ Male ◯ Female

What is your race: ◯ American Indian ◯ Asian ◯ Black/African American ◯ White ◯ Native Hawaiian/Pacific Islander ◯ Other Race

What is your ethnicity? ◯ Hispanic ◯ Non Hispanic ◯ Decline to Answer ◯ Unknown by patient

What is your preferred language? ◯ English ◯ Spanish

In the event you can't be reached, do we have permission to leave information on your voicemail system? ◯ Yes ◯ No

How did you hear about our office? ◯ ER ◯ Physician ◯ Friend ◯ Internet ◯ Newspaper ◯ Radio ◯ Phone Book ◯ Other

Family Physician | Referring Physician

City | State | Zip | City | State | Zip

1. What body part is involved with your PRIMARY orthopedic problem? *Please indicate the body part and side that is the primary reason for your appointment.*

UPPER EXTREMITY			*LOWER EXTREMITY*						*NECK/BACK*	
Collar bone	◯ Right	◯ Left	Lower leg	◯ Right	◯ Left	Foot	◯ Right	◯ Left	Neck	◯
Shoulder	◯ Right	◯ Left	Pelvis	◯ Right	◯ Left	Great toe	◯ Right	◯ Left	Upper back	◯
Arm	◯ Right	◯ Left	Hip	◯ Right	◯ Left	2nd toe	◯ Right	◯ Left	Mid back	◯
Elbow	◯ Right	◯ Left	Thigh	◯ Right	◯ Left	3rd toe	◯ Right	◯ Left	Low back	◯
Wrist	◯ Right	◯ Left	Knee	◯ Right	◯ Left	4th toe	◯ Right	◯ Left	Buttocks	◯
Hand	◯ Right	◯ Left	Knee cap	◯ Right	◯ Left	Small toe	◯ Right	◯ Left		
Thumb	◯ Right	◯ Left	Calf	◯ Right	◯ Left					
Index finger	◯ Right	◯ Left	Ankle	◯ Right	◯ Left					
Middle finger	◯ Right	◯ Left								
Ring finger	◯ Right	◯ Left								
Pinky finger	◯ Right	◯ Left								

HISTORY OF CURRENT PROBLEM

2. What is your PRIMARY orthopedic problem today?

◯ Pain ◯ Tingling ◯ Instability ◯ Stiffness ◯ Numbness ◯ Weakness ◯ Swelling

Other:

3. Is your orthopedic problem on the LEFT or RIGHT side, please indicate which side bothers you the greatest.

○ Right ○ Left

4. What is your dominant hand?

○ Right ○ Left

5. When was the onset of your current problem?

○ Unknown ○ Gradually
○ Suddenly, without injury ○ After an injury/accident

5a. Approximate date of injury or accident?

Month [ ] Day [ ] Year [ ]

5b. Where did the injury or accident take place?

○ Home ○ School ○ Sports
○ Motor Vehicle Accident (See 5d)
○ Work Related ○ Other - Please indicate below.

[ ]

5c. If your condition is due to a workplace injury, please answer the questions below.

Name of Employer:

[ ]

Date reported to your employer: ○ Not reported

Month [ ] Day [ ] Year [ ]

5d. If you have hired an attorney in relation to the injury or accident listed, please list name below.

[ ]

6. How did this injury occur? In your description, please include as much information as possible as to how and where the injury or accident happened. Please write in complete sentences.

[ ]

7. How long have the symptoms been present?

	1	2	3	4	5	6	7	8	9	10	11
Days	○	○	○	○	○	○	○	○	○	○	○
Weeks	○	○	○	○	○	○	○	○	○	○	○
Months	○	○	○	○	○	○	○	○	○	○	○
Years	○	○	○	○	○	○	○	○	○	○	○

8. On the scale below, mark the severity of the pain, 10 being the most severe.

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

KEY: None = 0; Mild = 1-3; Moderate = 4-7; Severe = 8-10

9. How can the current issue be characterized?

○ Intermittent ○ Constant ○ Burning
○ Dull ○ Sharp ○ Stabbing
○ Throbbing ○ Aching ○ Cramping
○ Pressure ○ Radiating ○ Electrical

10. Are the symptoms worse during the day or night?

○ No difference ○ Day ○ Night

11. What additional symptoms are present?

○ Chills ○ Fever ○ Numbness
○ Stiffness ○ Tingling ○ Weakness
○ Swelling ○ Instability ○ Fatigue
○ Headaches ○ Loss of feeling ○ Pain radiation
○ Sleep disturbance ○ Loss of bladder control
○ Loss of bowel control ○ Limit of motion

Other [ ]

12. Since the onset, what is the status of your problem?

○ Improved ○ Worsening ○ No change

13. Symptoms feel worse with?

○ Rest ○ Activity ○ Sitting
○ Lifting ○ Ice/Cold ○ Heat
○ Movement

Other [ ]

14. Symptoms improve with?

○ Rest ○ Activity ○ Medication
○ Ice/Cold ○ Heat ○ Movement

Other [ ]

15. Have you been seen by another physician for this problem?

- ◯ Yes
- ◯ No

If yes, list below the name of the treating physician.

____

16. What medications are you taking for this problem?

◯ Advil	◯ Flexeril	◯ Percocet
◯ Aleve	◯ Indocin	◯ Robaxin
◯ Arthrotec	◯ Lortab	◯ Relafen
◯ Aspirin	◯ Lyrica	◯ Skelaxin
◯ Celebrex	◯ Mobic	◯ Tylenol
◯ Darvocet	◯ Motrin	◯ Ultram
◯ Daypro	◯ Naprosyn	◯ Voltaren
◯ Feldene	◯ Neurontin	

Other ____________________

17. Please indicate any of the following treatment(s) you have had for this problem?

◯ Cortisone/Steroid Injection Date: __________

◯ Improved ◯ Worse ◯ Unchanged

◯ Synvisc/Hyalgan Injections Date: __________

◯ Improved ◯ Worse ◯ Unchanged

◯ TENS unit Date: __________

◯ Improved ◯ Worse ◯ Unchanged

◯ Bracing Date: __________

◯ Improved ◯ Worse ◯ Unchanged

◯ Chiropractor Date: __________

◯ Improved ◯ Worse ◯ Unchanged

18. Have you received Physical Therapy?

◯ Yes ◯ No

18a. How long did you receive Physical Therapy?

◯ <1 month	◯ 1 month	◯ 2 months
◯ 3-6 months	◯ 7-12 months	◯ 1 Year +

18b. Did physical therapy treatment help relieve your pain?

◯ Yes ◯ No

19. Indicate any past testing you've had done for this problem?

◯ Arthrogram	◯ MRI	◯ Bone Scan
◯ EMG	◯ Ultrasound	◯ CT Scan
◯ Lab Tests	◯ X-Rays	

Other ____________________

20. Indicate past medical conditions.

◯ No Significant History

EYES

◯ Blindness ◯ Glaucoma ◯ Glasses/Contacts

◯ Cataracts Other ____________________

EARS/NOSE/THROAT

◯ Chronic sinusitis ◯ Hearing loss ◯ Dental issues

Other ____________________

RESPIRATORY

◯ Asthma ◯ COPD/emphysema ◯ Sleep apnea

Other ____________________

CARDIAC (HEART)

◯ Coronary artery disease ◯ Myocardial infarction

◯ Heart failure/CHF ◯ Arrhythmia ◯ Heart surgeries

◯ High blood pressure ◯ High cholesterol

Other ____________________

GI

◯ Reflux/GERD ◯ Ulcers ◯ Hiatal hernia

◯ Constipation/diarrhea

Other ____________________

KIDNEY/LIVER

◯ Stones ◯ Renal insufficiency ◯ Dialysis ◯ Failure

◯ BPH/prostate disease ◯ Cirrhosis ◯ Hepatitis

◯ Blood in urine ◯ Infection

Other ____________________

SKIN

◯ Infection/Boils/Ulcers ◯ Rash ◯ Dermatitis

◯ Wound healing issues Other ____________________

MUSCULOSKELETAL/RHEUMATOLOGIC

◯ Fibromyalgia ◯ Lupus ◯ Gout ◯ Osteoporosis
◯ Rheumatoid arthritis ◯ Osteoarthritis

Other

NEUROLOGIC

◯ Seizure ◯ Parkinson's ◯ Migraine headaches
◯ Stroke / TIA / CVA

Other

PSYCHIATRIC

◯ Depression ◯ Bipolar ◯ Schizophrenia
◯ Developmental delay ◯ Anxiety

Other

ENDOCRINE

◯ Thyroid disease ◯ Insulin dependent diabetes
◯ Non insulin dependent diabetes ◯ HIV

Other

BLOOD / CIRCULATION

◯ Clotting issues ◯ DVT / PE
◯ Peripheral vascular disease

Other

CANCER

◯ Lungs ◯ Breast ◯ Prostate ◯ Kidney ◯ GI
◯ Bone ◯ Brain ◯ Colon ◯ Thyroid ◯ Skin
◯ Immune suppression

Other

21. Do you have any known allergies or reactions?

◯ No known allergies
◯ Eggs/Birds/Feathers ◯ Anesthesia ◯ Iodine
◯ Latex ◯ Codeine ◯ Penicillin ◯ Contrast dyes
◯ Adhesive tape/band aids ◯ Gold ◯ Nickel
◯ Silver ◯ Stainless steel ◯ Sulfa

Medications

Other

22. In the space provided, list all other medications you are taking, including non-prescription medications. *(Do not include medications you have previously listed).*

23. Have you had any surgeries at any time?

◯ Yes ◯ No

If yes, list all surgeries below.

Family History

24. Any history of medical conditions in your family?

◯ No ◯ Unknown
◯ Yes - please indicate below

◯ Arthritis ◯ Thyroid ◯ Cancer ◯ Stroke
◯ Prior joint replacement ◯ Diabetes
◯ General anesthesia problems ◯ Tuberculosis
◯ Gout ◯ Heart disease

Other

Social History

25. What is your marital status?

◯ Single ◯ Married ◯ Divorced ◯ Widowed

26. Do you live alone? ◯ Yes ◯ No

27. Are there stairs in your home? ◯ Yes ◯ No

If yes, indicate how many

Personal History

28. Do you use tobacco products?

◯ Never smoked ◯ Former smoker
◯ Dip/chew ◯ Current everyday smoker

28a. If a smoker, how many packs do you smoke per day?

◯ Less than one ◯ One pack ◯ Two packs
◯ Three plus packs

28b. How many years have you smoked/used tobacco?

◯ 1-5 years ◯ 6-10 years ◯ 11-20 years
◯ 20 plus years ◯ Sometimes smoker

28c. If you previously smoked, how long has it been since you quit smoking?

years [ ]

28d. If you previously smoked, how many years did you smoke before quitting?

years [ ]

29. Do you drink alcohol? ◯ Yes ◯ No

30. Do you exercise or play sports? ◯ Yes ◯ No

31. What is your employment status?

◯ Retired ◯ Student ◯ Homemaker
◯ On disability ◯ Unemployed
◯ Employed - list current occupation

Current occupation [ ]

32. Do you require assistance with walking?

◯ No ◯ Yes - If yes, what devices?
◯ Walker ◯ Wheelchair ◯ Cane
◯ Bilateral crutches / canes

Other [ ]

33. Any history of recreational drug use / steroids?

◯ No ◯ Yes - If yes, please explain below

[ ]

REVIEW OF SYSTEMS - Select all experienced within the last month

Constitutional Symptoms

Fever	◯ Yes	◯ No
Chills	◯ Yes	◯ No
Headache	◯ Yes	◯ No
Other		

Eyes

Blurred vision	◯ Yes	◯ No
Double vision	◯ Yes	◯ No
Pain	◯ Yes	◯ No
Other		

Neurological

Tremors	◯ Yes	◯ No
Dizzy spells	◯ Yes	◯ No
Numbness	◯ Yes	◯ No
Tingling	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Seizures	◯ Yes	◯ No
Difficulty standing	◯ Yes	◯ No
Difficulty walking	◯ Yes	◯ No
Balance issues	◯ Yes	◯ No
Weakness	◯ Yes	◯ No
Other		

Endocrine

Excessive thirst	◯ Yes	◯ No
Too hot/cold	◯ Yes	◯ No
Tired/sluggish	◯ Yes	◯ No
Other		

Gastrointestinal

Abdominal pain	◯ Yes	◯ No
Nausea/vomiting	◯ Yes	◯ No
Rectal bleeding	◯ Yes	◯ No
Loss of bowel control	◯ Yes	◯ No
Other		

Cardiovascular

Leg swelling/edema	◯ Yes	◯ No
High blood pressure	◯ Yes	◯ No
Leg cramps	◯ Yes	◯ No
Other		

Musculoskeletal

Osteoarthritis	◯ Yes	◯ No
Rheumatoid arthritis	◯ Yes	◯ No
Neck pain	◯ Yes	◯ No
Back pain	◯ Yes	◯ No
Use of cane/crutch	◯ Yes	◯ No
Other		

Ear/Nose/Throat

Ear infection	◯ Yes	◯ No
Sore throat	◯ Yes	◯ No
Trouble swallowing	◯ Yes	◯ No
Sinus problems	◯ Yes	◯ No
Dental problems	◯ Yes	◯ No
Other		

____
Patient Printed Name

____
Patient Signature

____
Date