# Patient Registration Form

**PATIENT INFORMATION** (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address _____ Language _____

Phone Numbers Home _____ Cell _____ Work _____

Race ☐ American Indian ☐ Asian ☐ Black or AA ☐ Caucasian ☐ Hawaiian ☐ Hispanic ☐ Refused ☐ Other _____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

**PRIMARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

**SECONDARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsible Party) Signature***_____ ***Date***_____

ORTHOPAEDIC HISTORY

Patient's Name:_____ Today's Date:_____

S.S#_____ Date of Birth:_____

CHIEF COMPLAINT

Why are you here today? _____

| Medication | Dose | Reason for Medication | Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Allergies: _____

Are all of your immunizations up to date? ___ YES __ NO

If NO which are due? _____

REVIEW OF SYSTEMS

Are you currently having or have had problems with you're:

| | Circle | | Describe all "YES" responses: |
|---|---|---|---|
| Eyes | NO | YES | |
| Ears, Nose, Throat | NO | YES | |
| Lungs, Breathing | NO | YES | |
| Digestion | NO | YES | |
| Bowel Movement | NO | YES | |
| Bladder Problems | NO | YES | |
| Diabetes | NO | YES | |
| High Blood Pressure | NO | YES | |
| Bleeding Problems | NO | YES | |
| Balance Problems | NO | YES | |
| Numbness/tingling | NO | YES | |
| Blackout/fainting | NO | YES | |

## ORTHOPAEDIC HISTORY

Patient's Name:_____ Today's Date:_____

## MEDICAL HISTORY

| | Circle | | Describe all "YES" responses: |
|---|---|---|---|
| Hepatitis | No | YES | |
| Psychological Problems | No | YES | |
| HIV/AIDS | No | YES | |
| Cancer | No | YES | |
| Arthtitis | No | YES | |
| Polio | No | YES | |
| TB | No | YES | |
| Epilepsy | No | YES | |
| Other: | | | |

## SURGICAL HISTORY

| Surgery | Date | Surgeon | Complications |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever had general anesthesia? ☐ YES ☐ NO

Have you had problems with anesthesia? ☐ YES ☐ NO

Describe: _____

Have you been hospitalized in the past? ☐ YES ☐ NO

If so, please explain the reason, what hospital and the date you were hospitalized: _____

What is your preferred pharmacy?

Name: _____

Address: _____

Telephone: _____

## ORTHOPAEDIC HISTORY

Patient's Name:_____ Today's Date:_____

## FAMILY HISTORY

| Member | Alive | Deceased | Age | Health Status/Cause of Death |
|---|---|---|---|---|
| Grandmother (mom's} | A | D | | |
| Grandfather (mom's) | A | D | | |
| Grandmother (dad's) | A | D | | |
| Grandfather (dad's) | A | D | | |
| Father | A | D | | |
| Mother | A | D | | |
| Sister/Brother | A | D | | |
| Sister/Brother | A | D | | |
| Sister/Brother | A | D | | |
| Sister/Brother | A | D | | |

## SOCIAL HISTORY

Retired Student Self Employed Employed (occupation) _____

Single Married Divorced Separated Widowed Partner

Children? NO YES if so, how many? ____ Do you live alone? NO YES

Exercise? Daily Weekly Monthly Rarely Never What? _____

History of substance abuse? NO YES What? _____

Smoke currently? NO YES _packs per day for ___ years

Quit Smoking? This year > 1year > 5 years >10 years

## REFERRING PHYSICIANS

PCP: _____

Address: _____

Telephone: _____ Fax: _____

## SPECIALIST

Name of Specialist: _____ Specialty: _____

Address: _____

Telephone: _____ Fax: _____

# First Point of Contact Screening

**Patient Name**_____ **Date**_____
Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms?
   If yes, please circle the symptoms you have now, or have had, over the past seven days? ☐ YES ☐ NO
   - fever
   - night sweats
   - sneezing or runny nose
   - severe headache
   - stiff neck
   - muscle or joint pain (circle one or both)
   - new rashes or open sores on your skin or in your mouth
   - redness, swelling, or discharge of your eyes (pink eye)
   - unexplained bleeding
   - vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? ☐ YES ☐ NO

   If yes, please list where: _____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? ☐ YES ☐ NO

   If yes, please list where: _____

**Thank you for your help and support in caring for our patients and community.**

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***TO BE FILLED OUT BY OFFICE STAFF***

Reviewed by:_____

Action taken:
- ☐ No action taken
- ☐ Isolate
- ☐ Cough/ hand washing etiquette provided
- ☐ Mark provided
- ☐ PM/ Lead clinical provided

*Thank you for trusting us with your healthcare!*