Registration Form

For internal office use only

MRN ________________

Date ________________

Patient Name: ______________________________
Last First MI

Address ________________
City ________________
State, Zip ________________
Home Phone ________________
Cell Phone ________________
Date of Birth __________ Age ______ Male/Female

Married Single Divorced Separated Widowed

Social Security # ________________
Driver License # ________________
Email ________________

Referred by ________________
Family Physician ________________
Emergency Contact # ________________
Name/Relationship ________________

Spouse's Name ________________
Spouse's Employer ________________

Patient's Employer ________________
Address ________________
City, State, Zip ________________
Work Phone ________________

PRIMARY INSURANCE/WORKER'S COMP

Carrier Name ________________
Subscriber's Name ________________
Subscriber ID ________________
Group # ________________
Subscriber's Date of Birth and SS# (if not self)
Date of Birth __________ SS# __________
Patient relationship to subscriber ________________

SECONDARY INSURANCE

Carrier Name ________________
Subscriber's Name ________________
Subscriber ID ________________
Group # ________________
Subscriber's Date of Birth and SS# (if not self)
Date of Birth __________ SS# __________
Patient relationship to subscriber ________________

RESPONSIBLE PARTY (if not patient)

Name ________________
Address ________________
City, State, Zip ________________
Phone ________________
SS# ________________

PLEASE GIVE YOUR INSURANCE CARDS AND PICTURE ID TO THE RECEPTIONIST

Describe your current problem ________________
When did the problem begin? __________ Do you have an Attorney? _____ Name ________________
Were you injured on the job? DATE __________ Were you injured in an auto accident? DATE __________
Do you have x-rays for this problem? __________ Where and when were they taken? ________________

AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment – Signature of Patient or Legal Guardian: ________________ Date __________

BENEFIT ASSIGNMENT/AGREEMENT TO PAY:

I hereby authorize my insurance benefits to be paid directly to Atlantic Orthopedics, PA. I understand that I am responsible to Atlantic Orthopedics, PA for payments made directly to me and for any services or charges not covered by my insurance carrier.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/RELEASE FOR TREATMENT:

I hereby authorize Atlantic Orthopedics, PA to release medical information (which may include treatment for physical/emotional illness, communicable disease, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS related information) to my insurance carrier and its designated, and in Worker's Compensation cases, to the patient's employer.

Signature of Patient or Legal Guardian: ________________ Date: __________

Patient Name: ______________________________ MRN: ______________________________

FINANCIAL POLICY

Payment for services rendered is due at time of service. I understand that I am financially responsible to the physicians of Atlantic Orthopedics, PA for services rendered and charges not covered by insurance. I understand that I am responsible for co-Payments, Deductibles and Co-Insurance amounts as called for in my insurance agreement. A $150.00 deposit for office visits or a 50% down payment for elective procedures is required from an uninsured patient prior to scheduling and/or receiving services. At the conclusion of the visit the balance will be due and payable. If the balance is not paid, Atlantic Orthopedics expects a minimum monthly payment of $50.00 until the balance is paid in full. Surgery and diagnostic procedures may require a larger monthly payment.

Signature of patient or Legal Guardian ______________________________ Date ______________

PATIENT HIPAA CONSENT FORM

Atlantic Orthopedics NOTICE OF PRIVACY PRACTICES provides information about how medical information about you may be used and disclosed and how you can get access to this information. This notice applies to all of your care generated by Atlantic Orthopedics, whether made by us or an associated facility. You have a right to review and/or receive a copy or notice before signing this consent.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures. You may designate persons you authorize Atlantic Orthopedics, PA to release your personal health information to.

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Signature of patient or Legal Guardian ______________________________ Date ______________

Atlantic Orthopedics — Medical History Questionnaire

Patient Name ____________________ Age ______ Date of Birth ______________

Height ________ Weight ________ *Temperature* ______ *Pulse* _____ *Blood Pressure* __________

What is the reason for your visit today? ______________________________

What is your preferred Pharmacy/Drug Store? ______________________________

Please check below if you have, or have had, any of these medical conditions:

- ☐ Eye problems
- ☐ Hearing loss
- ☐ Dental pain or loose or rotten teeth
- ☐ Atrial fibrillation or erratic heart beat
- ☐ Coronary Artery Disease
- ☐ Angina chest pain or pressure
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ High blood pressure (hypertension)
- ☐ Peripheral Vascular Disease
- ☐ Poor circulation to your legs
- ☐ Blood clot to your legs (phlebitis)
- ☐ Lung problems
- ☐ Pneumonia
- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Blood clot to the lung
- ☐ Stomach or intestinal problems
- ☐ Acid reflux of the esophagus
- ☐ Bleeding from stomach or intestines
- ☐ Gastritis
- ☐ Stomach ulcers
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Diverticulosis
- ☐ Gall bladder disease
- ☐ Hepatitis or turning yellow jaundice
- ☐ Kidney disease
- ☐ Kidney infection
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Polycystic kidney disease
- ☐ Frequent bladder infections
- ☐ Cystic Fibrosis
- ☐ Elevated Cholesterol
- ☐ Hemochromotosis
- ☐ Hyperthyroid (over active thyroid)
- ☐ Hypothyroid (under active thyroid)
- ☐ Diabetes or Sugar
- ☐ Psoriasis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Lupus arthritis
- ☐ Significant Head Injury
- ☐ Migraine headaches
- ☐ Epilepsy or seizures
- ☐ Leukemia
- ☐ Alzheimer's or significant memory loss
- ☐ Parkinsonism
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Mini-stroke or Transient ischemic attack (TIA)
- ☐ Stroke
- ☐ Depression
- ☐ Excessive anxiety or panic attacks
- ☐ HIV infection or AIDS
- ☐ Tuberculosis
- ☐ Venereal disease
- ☐ Anemic
- ☐ Adverse reaction to anesthesia
- ☐ Cancer
- ☐ Colon cancer
- ☐ Lung cancer
- ☐ Melanoma of skin
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Kidney cancer
- ☐ Other not listed, explain: ______________

Family and Social History

Do you smoke daily?	Y	N
Do you drink Alcohol daily?	Y	N
Do you use recreational drugs?	Y	N
Do you exercise daily?	Y	N
Do you live alone?	Y	N

Single ☐ Married ☐ Divorced ☐

Please indicate if any of your immediate family members have any of the following:

- ☐ Osteoarthritis (Joint Problems)
- ☐ Rheumatoid arthritis
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ High blood pressure (hypertension)
- ☐ Stroke
- ☐ Diabetes or Sugar

Please check below if you have had any of these surgeries:

- ☐ Angioplasty of heart arteries
- ☐ Tonsillectomy
- ☐ By-Pass surgery of heart arteries
- ☐ Heart valve replacement: ☐Aortic valve or ☐Mitral valve
- ☐ By-pass of artery of leg or arm
- ☐ Abdominal Aortic Aneurysm
- ☐ Varicose vein surgery of legs
- ☐ Breast surgery: Mastectomy
- ☐ Gastric By-Pass for obesity
- ☐ Partial / complete removal of colon
- ☐ Partial removal of small intestines
- ☐ Appendectomy
- ☐ Gallbladder surgery
- ☐ Hernia repair
- ☐ Hysterectomy but ovaries remain
- ☐ Total Hysterectomy
- ☐ C-Section
- ☐ Laparoscopy of Abdomen
- ☐ Prostate Surgery/TURP
- ☐ Total removal of Prostate
- ☐ Spine surgery
- ☐ Shoulder surgery
- ☐ Wrist surgery
- ☐ Hand Surgery
- ☐ Hip surgery
- ☐ Knee surgery
- ☐ Ankle surgery
- ☐ Foot surgery
- ☐ Other not listed, explain: ______________

I certify that this information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature ______________________ Date ____________

Physician/PA seen today: ______________

MRN: ______________

Atlantic Orthopedics – Review of Systems & Medications

Patient Name ______________________________ Age ______ Date of Birth ______________

Please check below if you are experiencing any of the following:

- ☐ Are you feeling tired or poorly
- ☐ Running a fever
- ☐ Experiencing chills
- ☐ Excessive weight loss or weight gain.
- ☐ Headache
- ☐ Sinus pain or pressure
- ☐ Eyesight problems
- ☐ Blind spots in your vision
- ☐ Double vision
- ☐ Loss of hearing
- ☐ Earache
- ☐ Ringing in your ears
- ☐ Sore throat
- ☐ Painful teeth
- ☐ Loose teeth
- ☐ Bleeding gums
- ☐ Chest pain or tightness
- ☐ Chest pain radiating to right arm or neck
- ☐ Chest pain or pressure with exertion
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Awakening at night with shortness of breath
- ☐ A significant cough
- ☐ Coughing up blood
- ☐ Sweating heavily at night
- ☐ Loss of appetite
- ☐ Heartburn
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Black or tarry stools
- ☐ Red blood in bowel movements
- ☐ Abnormal amount of Diarrhea
- ☐ Significant Constipation
- ☐ Pain during urination
- ☐ Loss of control of urine
- ☐ Urinating much more frequently
- ☐ Blood in urine
- ☐ Excessive thirst/ too thirsty
- ☐ Cold weather bothers you more than before
- ☐ Any skin rashes
- ☐ Any open skin sores
- ☐ Moles that look abnormal or changed
- ☐ Any abnormal bruising of the skin
- ☐ Any ankle swelling
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Dizziness
- ☐ Any weakness of arms or legs
- ☐ Any numbness or tingling of arms or legs
- ☐ Bothersome anxiety
- ☐ Significant depression
- ☐ Insomnia or difficulty sleeping
- ☐ Sleep apnea: episodes of not breathing while sleeping
- ☐ Any thoughts of suicide
- ☐ Other Symptoms, explain: ______________________

Please check below if you are taking any of the following medications:

- ☐ Coumadin
- ☐ Warfarin
- ☐ Aspirin
- ☐ Tylenol (Acetomenophen)
- ☐ Lipitor
- ☐ Mevacor
- ☐ Zocor
- ☐ Lisinopril
- ☐ Enalapril
- ☐ Vasotec
- ☐ Ramipril
- ☐ Altace
- ☐ HCTZ (hydrochlorothiazide)
- ☐ Maxzide
- ☐ Dyazide
- ☐ KCL (potassium)
- ☐ Celebrex
- ☐ Bextra
- ☐ Motrin (Advil/Ibuprofen)
- ☐ Plavix
- ☐ Naprosyn,Aleve,Naproxen
- ☐ Percocet
- ☐ Oxycodone
- ☐ Oxycontin
- ☐ Vicodin (hydocodone)
- ☐ Tylenol #3 (codeine)
- ☐ Tamoxifen
- ☐ Fosamax
- ☐ Glucophage (Metformin)
- ☐ Avandia
- ☐ Glyburide
- ☐ Glipizide
- ☐ Glucotrol
- ☐ Viagra, Levitra, or Cialis
- ☐ Other, not listed, explain: ______________________

ALLERGIES Please indicate any Drugs or other Substances that you are allergic to: ______________________

Or,
Initial the following statement: ________ I am not allergic to any drug or substance that I know of.

I certify that this information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Physician/PA seen today: ______________________

MRN: ______________________

____
Signature Date