PATIENT REGISTRATION FORM

Today's Date: ___________________________

PATIENT INFORMATION

Last Name: _______________________________________ First: ___________________________________ Mi. Init: ________

DOB: ___________________ Age: _______ SSN: ________________________ Gen: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Other

Address: ____ City: ________________________ State: ______ Zip: _____________

Preferred phone #: ______________________________________ Secondary phone #: _____________________________________

select: ☐ CELL ☐ HOME ☐ WORK *select:* ☐ CELL ☐ HOME ☐ WORK

Email address: ____

Occupation: _______________________________________ Employer: ____

Employer Address: ___________________________________ City: ________________________ State: ______ Zip: _____________

Employer Contact Person: ____________________________________ Employer Phone #: __________________________________

EMERGENCY CONTACT

Name: ____ Relationship to patient: ________________________

Preferred phone #: ______________________________________ Secondary phone #: _____________________________________

select: ☐ CELL ☐ HOME ☐ WORK *select:* ☐ CELL ☐ HOME ☐ WORK

REASON FOR VISIT / PHYSICIAN INFO

Reason for appointment: ____ Date symptoms began: _________________

Referring Physician *(if applicable)*: ____ Phone #: _______________________________

Referring Address: ___________________________________ City: ________________________ State: ______ Zip: _____________

Primary Care Physician: ____ Phone #: _______________________________

PCP Address: ____ City: ________________________ State: ______ Zip: _____________

PHARMACY

Preferred Pharmacy: ____ Phone #: ______________________________

Address: ____ City: ________________________ State: ______ Zip: _____________

HEALTH INSURANCE

Primary Insurance: ____ Insurance Phone #: _________________________________

Policy #: ____ Group ID #: ____

Policy Holder's Last Name: ________________________________ First Name: ________________________ DOB: ______________

Policy Holder's SSN: ________________________________ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy Holder's Employer: ____ Employer Phone #: ____________________________

Employer Address: ___________________________________ City: ________________________ State: ______ Zip: _____________

Secondary Insurance: _______________________________________ Insurance Phone #: __________________________________

Policy #: ____ Group ID #: ____

Policy Holder's Last Name: ________________________________ First Name: ________________________ DOB: ______________

Policy Holder's SSN: ________________________________ Relationship to patient: □ Self □ Spouse □ Parent □ Other

Policy Holder's Employer: ____ Employer Phone #: ____________________________

Employer Address: ___________________________________ City: ________________________ State: ______ Zip: _____________

GUARANTOR/LEGAL GUARDIAN *(if applicable)*

□ Parent □ Legal Guardian □ Other Last Name: _____________________________ First Name: _________________________

DOB: _____________ SSN: ___________________ Relationship to patient: ____________________ Phone #: ___________________

Address: ____ City: ________________________ State: ______ Zip: _____________

WORKERS' COMP INFORMATION *(if applicable)*

Is this a work-related injury? □ YES □ NO Did you report it? □ YES □ NO Did your employer approve this visit? □ YES □ NO

Date/Time of injury: _________________________________ Part of body injured: ____

Contact person at place of employment: ____ Date last worked: ___________________

Workers' Compensation Carrier: ____ Claim #: __________________________________

Address: ____ City: ________________________ State: ______ Zip: _____________

Adjuster's Name: ____ Phone #: _____________________________

ACCIDENT/PERSONAL INJURY INFORMATION *(if applicable)*

Motor vehicle/personal injury? □ YES □ NO Date/Time of accident: ________________________ State accident occurred: ______

Insurance Carrier: _____________________________ Claim #: ____________________________ Phone #: ____________________

Address: ____ City: ________________________ State: ______ Zip: _____________

ATTORNEY INFORMATION *(if applicable)*

Attorney's name: ____ Phone #: _______________________

Address: ____ City: ________________________ State: ______ Zip: _____________

HOW DID YOU LEARN ABOUT PARKVIEW? *(Please be specific.)*

□ Family/Friend □ Physician (specify): ____

□ Have been our patient in the past □ Hospital/Urgent Care (specify): _____________________________________

□ Workers' Comp Case Manager or Attorney □ Coach/Trainer (specify): ____

□ Internet (*circle:* Google/Facebook/Parkview Website/Yelp/Healthgrades) □ Other (specify): ____________________________

All of the information provided is complete and accurate to the best of my knowledge.

____ ________________________

PATIENT SIGNATURE DATE

YOUR PHOTO ID, INSURANCE CARD, AND COPAY ARE REQUIRED AT THE TIME OF THE VISIT. IF YOU DO NOT HAVE YOUR INSURANCE CARD AVAILABLE, ALL CHARGES WILL BE YOUR RESPONSIBILITY AND PAYABLE AT THE TIME OF SERVICE. OBTAINING ANY REQUIRED REFERRAL FORMS IS YOUR RESPONSIBILITY, AS ARE ALL UNPAID BALANCES AND/OR DENIED CLAIMS.

PATIENT INFORMATION SHEET

Please complete all four pages of this form

Name: ______________________________ Date: ______________

Date of Birth: ______________ Age: ______ Occupation: ______________________

Type of work done: ____

Who referred you to this office? ________________________________

Significant sporting or recreational activities: ________________________

What is the main reason for your visit? (e.g. pain, weakness, numbness, scoliosis): ______________

____

Where is the pain/numbness? (e.g. neck, right arm, low back, left thigh, shoulder, hip, etc.) ______________

____

When did your back or neck symptoms begin? ________________________

When did your arm or leg symptoms begin? ________________________

Is this related to an injury? (yes/no/possibly) ______________ Date of injury: ______________

Classify the injury:

- ❑ Injury on the job
- ❑ Vehicular accident; State accident occurred: ______________
- ❑ Sporting injury
- ❑ Slip & fall
- ❑ Lifting/bending
- ❑ Other: ________________________

Please describe the injury (e.g. stopped at a traffic light when rear-ended, or bent over to pick up a box, or no known injury)

____

If you were injured on the job, was an injury report filed? ❑ Yes ❑ No

Who was your employer at the time of the injury? ________________________

Work Status:

- ❑ Employed without restrictions or limitations
- ❑ Employed with restrictions or limitations
- ❑ Homemaker without restrictions or limitations
- ❑ Homemaker with restrictions or limitations
- ❑ Temporarily not working because of pain
- ❑ Released from work because pain prevents job completion
- ❑ Not employed
- ❑ On disability
- ❑ Student
- ❑ Retired
- ❑ On Workman's Compensation
- ❑ Other: ____

Legal Action:

❑ None ❑ Potential ❑ Progressing ❑ Settled

Do you have a living will? ❑ Yes ❑ No

Do you have either bowel or bladder incontinence? ❑ Yes ❑ No

If yes, please explain: ____

Are your symptoms worse in the:

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ Varies ❑ Does not apply

Does the pain waken you during the night? ❑ Yes ❑ No

What is the one activity or position which best relieves your symptoms? ____

____

What is the one activity or position that makes your symptoms their worst? ____

____

What can you not do because of your pain? ____

____

Which of the following diagnostic tests have you had done:

❑ None ❑ X-rays ❑ MRI ❑ CT Scan ❑ Myelogram ❑ EMG ❑ Bone Scan

Other: ____

Do you have a family history of spinal problems? ❑ Yes ❑ No

SOCIAL HISTORY:

Who do you live with? ❑ Family ❑ Friends ❑ Alone ❑ Other: ______________________________

Do you smoke: ❑ Yes ❑ No If yes, how many packs per day? ____________

Do you drink alcohol? ❑ None ❑ Rarely ❑ Socially ❑ Daily

MEDICAL HISTORY:

Physician's name: ________________________________ Date of last physical: ________________

Do you have any medical problems?

❑ None	❑ Ulcers
❑ High blood pressure	❑ Diabetes
❑ Heart attack	❑ Blood clots
❑ Cancer	❑ Thyroid
❑ Hepatitis	❑ Mitral valve prolapse
❑ Asthma	❑ Other: _________________________

List all your past surgeries (for any surgeries performed in the past three years, list the month and year) ____________

____

What medications do you regularly take, or are you currently taking? ________________________________

____

List the medications to which you are allergic: ____

GENERAL REVIEW OF SYSTEMS: Please check yes or no, for current and unexplained symptoms.

Recent unexplained weight loss	❑ Yes	❑ No
Blurred or double vision	❑ Yes	❑ No
Hearing loss or ringing	❑ Yes	❑ No
Chest pain	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No
Nausea or vomiting	❑ Yes	❑ No
Blood in stool	❑ Yes	❑ No
Burning or painful urination	❑ Yes	❑ No
Rash or itching	❑ Yes	❑ No
Light headed or dizzy	❑ Yes	❑ No
Memory loss or confusion	❑ Yes	❑ No
Bleeding or bruising tendency	❑ Yes	❑ No
Fever	❑ Yes	❑ No

HAVE YOU HAD PRIOR BACK OR NECK SURGERY? ❑ Yes ❑ No

INFORMATION REGARDING PREVIOUS SPINE SURGERY

Name: ______________________________ Date: ______________

Anatomical location of previous spine surgery:

- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar

Procedure:

- ❑ Laminectomy
- ❑ Discectomy
- ❑ Fusion with metal
- ❑ Fusion without metal
- ❑ Anterior (front) procedure
- ❑ Posterior (back) procedure
- ❑ Date of surgery: ____________________

Date of onset of symptoms before surgery: ______________________________

Symptoms before surgery (e.g. pain, numbness, weakness): ______________________________

____

Location of symptoms before surgery (e.g. arm, leg, back, neck): ______________________________

____

Describe specific location of symptoms on extremities (e.g. back of thigh, back of calf, bottom of foot):

____

____

Was surgery a success?

❑ Yes ❑ No ❑ Partial

Post-op improvement:

❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

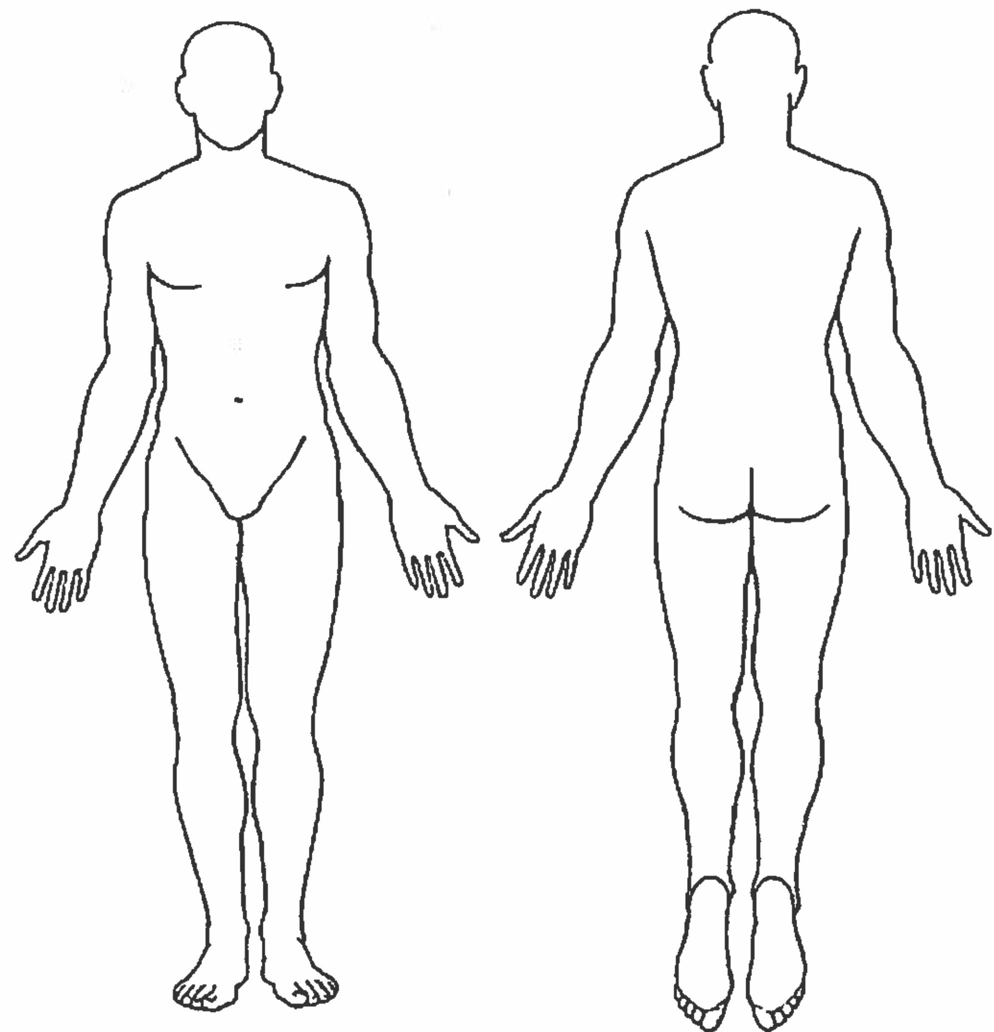
❑ None ❑ Surgery worsened my symptoms

How long were your symptoms absent after surgery? ______________________________

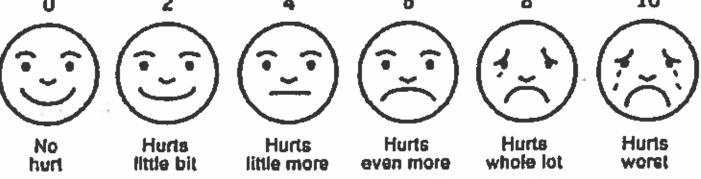
____

Mark the area of your body where you feel abnormal sensations and / or pain. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness: - - - - - - - - - - - - - - - -
Pins and needles: • • • • • • • • • • • • • • • •
Burning: xxxxxxxxxxxxxxxxxx
Stabbing: //////////////////
Pain: + + + + + + + + + + + + + + + +



Please circle the number which represents your average pain over the past week:



PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by **Parkview Orthopaedic Group** (the Practice) and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. **(_______)**
INITIAL

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my Personal Health Information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. **(_______)**
INITIAL

I authorize the Practice to release information about my medical condition to the following people:

Name: _________________________________ **DOB:** ________________ **Relationship:** ______________________

Name: _________________________________ **DOB:** ________________ **Relationship:** ______________________

PATIENT COMMUNICATIONS. I consent to be contacted by the Practice or anyone calling on its behalf for any reason, including appointment reminders and regarding past due patient balances. I authorize the Practice to contact me at any telephone number or physical or electronic address I provide. I agree that the Practice may contact me in any way, including calls or text messages delivered by an automatic telephone dialing system, or email messages delivered by an automatic emailing system. I agree to promptly notify the Practice at any time my contact information changes. **(_______)**
INITIAL

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees. **(_______)**
INITIAL

PRIVACY POLICY. I acknowledge having received the Practice's "Notice of Privacy Practices." My rights, including the rights to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the practice has already made disclosures with my prior consent. **(_______)**
INITIAL

This consent was signed by (Patient or Authorized Person): ***Relationship (if not patient):***

____ ___________________________________

PRINT NAME

Signature: ____ ***Date:*** ______________________

If patient is unable to sign, verbal consent may be given. ***Reason***: ____

Witness Signature: ____ ***Date:*** ______________________