PARKVIEW ORTHOPAEDIC GROUP

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: _____ Phone #: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Preferred phone #: _____ Secondary phone #: _____

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

VISIT INFORMATION

Reason for appointment: _____ Date symptoms began: _____

Primary Care Physician: _____ City: _____

Referring Physician *(if other than PCP)*: _____ City: _____

Preferred Pharmacy: _____ City: _____ Phone #: _____

HEALTH INSURANCE

Primary Insurance: _____ Policy #: _____ Group ID #: _____

Who is the insurance policy holder? ☐Self ☐Spouse ☐Parent ☐Other _____

If not "self"…

Policy Holder's Name: _____ DOB: _____ SSN: _____

Policy Holder's Employer: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Policy #: _____ Group ID #: _____

Who is the insurance policy holder? ☐Self ☐Spouse ☐Parent ☐Other _____

If not "self"…

Policy Holder's Name: _____ DOB: _____ SSN: _____

GUARANTOR/LEGAL GUARDIAN *(if applicable)*

□ Parent □ Legal Guardian □ Other 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)*

Is this a 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

□ Have been our patient in the past

□ Internet search

□ Facebook

□ Insurance Company

□ Workers' Comp case manager or attorney

□ Physician (*who?)*: _____

□ Hospital or Urgent Care (*which one?*): _____

□ Coach/Trainer (*who?*): _____

□ Health Fair (*where/when?*): _____

□ Physician lecture (*where/when?*): _____

□ 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.

PARKVIEW ORTHOPAEDIC GROUP

PATIENT HISTORY / Dr. Anis Mekhail

Adult & Pediatric Spine Surgery

Today's Date: _____

Name: _____ Age: _____ Sex: ☐ Male ☐ Female

Hand dominance: ☐ Right ☐ Left Occupation: _____

PATIENT HISTORY

What problem would you like addressed at today's visit? (*Select all that apply.)*

☐ Pain ☐ Deformity ☐ Mass ☐ Traumatic injury ☐ Numbness ☐ Weakness ☐ Other _____

Pain score: (0-10 / 10): _____ Location of problem: _____

Date of injury/onset: _____ Duration: _____

How did the injury or problem start? _____

Problem improves with: _____ Problem gets worse with: _____

What activities are you not able to do because of your current problem? _____

Any additional information: _____

What prior treatment(s) have you tried? _____

Have you had any prior tests related to this problem?

☐ X-ray ☐ CT Scan ☐ MRI Date of test(s) (if you recall): _____

Are you currently working or participating in a sport or other high intensity activity? ☐ YES ☐ NO

School/sport/position/occupation/job description/etc.: _____

MEDICAL HISTORY

☐ Tumor or cancer	☐ Tuberculosis	☐ Blood disease or anemia	☐ Convulsions
☐ Pneumonia	☐ Blood clots	☐ Fainting spells	☐ Shortness of breath
☐ Liver disease	☐ Disabling headaches	☐ Polio	☐ Gallbladder trouble
☐ Nervous disorder	☐ Coughing up blood	☐ Stomach trouble or ulcers	☐ Skin rash
☐ Chest pain	☐ Rectal bleeding	☐ Goiter or thyroid trouble	☐ Heart murmur
☐ Kidney trouble	☐ Diabetes	☐ Blood pressure trouble	☐ Blood in urine
☐ Asthma	☐ Rheumatic fever	☐ Dislocation	☐ Heart trouble
☐ Back pain/disorder	☐ Broken bone	☐ Albumen or sugar in urine	☐ Arthritis
☐ Foot trouble	☐ Muscle weakness	☐ Paralysis	☐ Calf pain

Please explain the details of any conditions you selected above:

_____

_____

SURGICAL HISTORY

PREVIOUS SURGERY	YEAR	NAME OF PHYSICIAN

MEDICATIONS (*Please include over-the-counter, vitamins, etc.)*

NAME OF MEDICINE	DOSAGE	TIMES PER DAY

ALLERGIES *(Please list ALL allergies, including medications, environmental allergies, food, metal/jewelry, latex, etc.)*

_____

_____

_____

SOCIAL HISTORY

Do you smoke tobacco? □ Never smoker □ Current every day smoker Years smoked: _____

□ Former smoker □ Current occasional smoker Packs per day: _____

Do you consume alcohol? □ YES □ NO If yes, approximate number of drinks per week: _____

Do you use recreational drugs? □ YES □ NO

FAMILY HISTORY

Does anyone in your family have: Blood clotting problem/disorder? □ YES □ NO Bleeding disorder? □ YES □ NO

Details: _____

PARKVIEW ORTHOPAEDIC GROUP

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 (PHI). I authorize use and disclosure of my PHI 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. 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 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: _____**

CANCELLATION/NO-SHOW POLICY: I understand that the Practice requires a 24-hour advance notification for the cancellation of a scheduled appointment for a physician, physical therapy, x-ray, MRI, etc. This allows the Practice to accommodate other patients seeking appointments. I understand that if I cancel an appointment without 24-hour notice, or fail to show for my scheduled appointment, I will be subject to a fee of $50.00. I know that my physician has no discretion regarding the matter. **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: _____**

_____ _____

PRINT NAME (Patient or Authorized Person who is signing consent) ***RELATIONSHIP (if not patient)***

Signature: _____ ***Date:*** _____

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

Witness Signature: _____ ***Date:*** _____