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

MEDICAL INFORMATION

Primary Care Physician: _____ City: _____ Phone #: _____

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

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. Kevin Bigart

Primary and Revision Hip and Knee Replacement

Today's Date: _____

Name: _____ **Date of birth:** _____

Why are you coming to see the doctor today?

_____

_____

_____

_____

Are you having any pain with this problem? ☐ YES ☐ NO

If "yes," is pain your primary complaint? ☐ YES ☐ NO

If "no," what is your primary complaint/symptom? _____

How long have you had this problem? _____

Is this problem: ☐ Getting worse ☐ Getting better ☐ Staying the same

Is your problem: ☐ Intermittent ☐ Constant

Do you have any of the following? ☐ Stiffness ☐ Swelling ☐ Numbness ☐ Weakness

Do you need assistance with walking? ☐ None ☐ Cane, long walks only ☐ Cane, all of the time ☐ Walker ☐ Wheelchair

Do you walk with a limp? ☐ None ☐ Slight ☐ Moderate ☐ Severe ☐ Unable to walk

If "unable to walk," how long ago was the last time you walked with or without an assistive device? _____

Do you have difficulty going up/down stairs? ☐ None ☐ Take one step at a time ☐ Use banister always ☐ Cannot do stairs without assistive device

How many stairs do you walk up <u>to get into</u> your home? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ More than 10

How many stairs must you walk up <u>inside</u> of your home? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ More than 10

Do you have a bathroom on the first floor of your home? ☐ YES ☐ NO

Do you have difficulty putting on your shoes & socks? ☐ None ☐ With difficulty ☐ Unable (I need help with this)

Can you sit in a chair comfortably? ☐ Any chair for more than 1 hour ☐ High chair for half hour ☐ Unable to sit for half hour

Can you get up from a chair? ☐ Normally ☐ Use of my arms ☐ Difficulty, even when using arms ☐ Need help, unable to do this

Name: _____

*******Skip this ENTIRE page if you are not having any pain at all*******

How long have you been having pain? _____

Is this pain: ☐Getting worse ☐ Getting better ☐ Staying the same

Is this pain: ☐ Intermittent ☐ Constant

Rate your pain on a scale from 1-10 (1=minimal pain, 10=severe pain): _____

How would you rate your hip/knee today as a percentage of normal (0 to 100% with 100% being normal)? _____

If you are having HIP pain

Where is the pain located? ☐ Groin ☐ Side of hip ☐ Thigh ☐ Buttock

Does the pain radiate? ☐ It doesn't radiate ☐ Yes, it radiates

If yes, where to? ☐ Down to the knee ☐ Down below the knee ☐ Down to the foot

If you are having KNEE pain

Where is the pain located? ☐ Inside of the knee (close to other knee) ☐ Front of the knee (under kneecap)

☐ Outside of the knee (away from other knee) ☐ Back of the knee

Does the pain radiate? ☐ It doesn't radiate ☐ Yes, it radiates

If yes, where to? ☐ Up to the hip ☐ Down to the foot ☐ Comes down the back of my leg

How would you describe the nature of your pain? ☐ Sharp ☐ Throbbing ☐ Burning ☐ Dull ☐ Tight ☐Tingling

When do you have pain? ☐Walking up/down stairs ☐Walking ☐ Standing ☐ Sitting ☐ Laying down/at rest

Pain is the worst with: ☐ Walking up/down stairs ☐ Walking ☐ Standing ☐ Sitting ☐ Laying down/at rest

How far can you walk BEFORE you start having pain? ☐ Don't get pain walking ☐ 4-6 blocks ☐ 2-3 blocks

☐ Indoors only ☐ Bed to chair only ☐ Unable to walk

Have you tried any of the following medication?

☐ Tylenol ☐ Aspirin ☐ Celebrex ☐ Tramadol ☐Other _____

☐ Ibuprofen (Motrin/Advil) ☐ Alieve ☐ Mobic ☐ Narcotics

Which are you still taking? _____

Have you tried injections? ☐ YES ☐ NO

If "yes," what type of injection? ☐ Steroid/cortisone ☐Hyaluronic acid ("gel")- which one? _____

☐ Stem cell ☐ Other _____

If "yes," how many injections have you had? _____ How long ago was your last injection? _____

Have you tried physical therapy? ☐ YES ☐ NO

Please provide any additional comments about your pain that are not covered above:

_____

_____

Name: _____

PAST MEDICAL HISTORY

Please list all your medical problems (for example: high blood pressure, diabetes, heart disease, etc.)

_____

_____

Please list all your past surgeries/hospitalizations/severe injuries with dates

SURGERY/HOSPITALIZATION/INJURY	MONTH/YEAR

Are you currently taking a blood thinner? ☐ Aspirin ☐ Coumadin (Warfarin) ☐ Eliquis ☐ Lovenox (Heparin) ☐ Plavix ☐ Xarelto ☐ Other: _____

If "yes," what are you taking it for? _____

How long do you/your doctor expect you to be on it? ☐ Lifetime ☐ Other: _____

Please list all other current medications

MEDICATION NAME	DOSAGE	HOW OFTEN YOU TAKE IT	HOW LONG YOU'VE BEEN TAKING THIS MEDICATION

SOCIAL HISTORY

What kind of work do you do? ☐ Homemaker ☐ Manual labor ☐ Desk job ☐ On disability ☐ Retired

Other occupation: _____

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you live alone? ☐ YES ☐ NO If "no," who lives at home with you? _____

Do you drink alcohol? ☐ YES ☐ NO If "yes," number of drinks per week: _____

Do you use tobacco products? ☐ YES ☐ NO If "yes," how long have you used tobacco products? _____

What products? ☐ Cigarettes ☐ Cigar ☐ E-cigarette ☐ Smokeless

Do you use illicit drugs? ☐ YES ☐ NO If "yes," describe: _____

Do you exercise regularly? ☐ YES ☐ NO If "yes," how many times/week? _____ Length of each workout (mins)? _____

Do you follow a special diet? ☐ YES ☐ NO If "yes," what kind? _____

FAMILY HISTORY

			AGE	HEALTH STATUS/CAUSE OF DEATH
Father	☐ ALIVE	☐ DECEASED		
Mother	☐ ALIVE	☐ DECEASED		
Sibling	☐ ALIVE	☐ DECEASED		
Sibling	☐ ALIVE	☐ DECEASED		
Sibling	☐ ALIVE	☐ DECEASED		

Name: _____

Do you currently or have you ever had problems with any of the following?

CONSTITUTIONAL

- Recent Weight Loss ☐ YES ☐ NO
- Recent Weight Gain ☐ YES ☐ NO
- Recent Fevers ☐ YES ☐ NO

HEAD

- Headache ☐ YES ☐ NO

EYES

- Visual loss ☐ YES ☐ NO
- Wear glasses/contacts ☐ YES ☐ NO

EARS, NOSE, THROAT

- Ear Drainage ☐ YES ☐ NO
- Nasal Congestion ☐ YES ☐ NO
- Pain/difficulty swallowing (dysphagia) ☐ YES ☐ NO

RESPIRATORY

- Cough ☐ YES ☐ NO
- Shortness of breath (dyspnea) ☐ YES ☐ NO
- Known Tuberculosis exposure ☐ YES ☐ NO

CARDIOVASCULAR

- Chest pain ☐ YES ☐ NO
- Heart murmur ☐ YES ☐ NO
- Leg swelling ☐ YES ☐ NO
- Irregular heartbeat/palpitations ☐ YES ☐ NO

GASTROINTESTINAL

- Abdominal pain ☐ YES ☐ NO
- Constipation ☐ YES ☐ NO
- Diarrhea ☐ YES ☐ NO
- Nausea ☐ YES ☐ NO
- Vomiting ☐ YES ☐ NO

GENITOURINARY

- Painful (i.e. burning) urination (dysuria) ☐ YES ☐ NO
- Blood in urine (hematuria) ☐ YES ☐ NO

METABOLIC/ENDOCRINE

- Hair loss ☐ YES ☐ NO

NEUROLOGICAL

- Dizziness ☐ YES ☐ NO
- Memory impairment ☐ YES ☐ NO
- Tingling or "pins and needles" sensation in arms or legs (paresthesia) ☐ YES ☐ NO
- Seizures ☐ YES ☐ NO

PSYCHIATRIC

- Anxiety ☐ YES ☐ NO
- Depression ☐ YES ☐ NO

INTEGUMENTARY

- Itchy skin ☐ YES ☐ NO
- Rash ☐ YES ☐ NO
- Skin infections ☐ YES ☐ NO

HEMATOLOGIC

- Easy bleeding (i.e. routinely bleed when brushing teeth) ☐ YES ☐ NO
- Easy bruising ☐ YES ☐ NO

IMMUNOLOGIC

- Contact allergy ☐ YES ☐ NO
- Skin reacts when wearing cheap jewelry ☐ YES ☐ NO
- Seasonal allergy ☐ YES ☐ NO

ANTHROPOMETRICS

Height: _____ Weight (pounds): _____ BMI: _____

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:*** _____

PARKVIEW ORTHOPAEDIC GROUP

AUTHORIZATION FOR CREDIT CARD ON FILE PAYMENT

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE #: _____

EMAIL: _____ ACCOUNT #: _____

At Parkview Orthopaedic Group, S.C., we require keeping your credit/debit or HSA card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your card information is kept confidential and secure and will be processed only after the claim has been filed and processed by your insurer.

You will receive your statement by mail and payment is expected upon receipt. If the balance due remains unpaid, we will begin the process of charging the card on file to satisfy the balance. You will receive an email notification prior to your card being charged, if you have provided us with a valid email address.

You may be asked for authorization for additional payments, for example:

- A deposit when a procedure/surgery is scheduled.
- Your Physical Therapy insurance benefit includes a deductible, co-pay or co-insurance amount.
- Your surgery claim has been adjudicated by your insurance.
- Outstanding balances.

Until further notice, I authorize Parkview Orthopaedic Group to charge the patient-responsible balances (co-pays, co-insurance, deductibles and non-covered services) to the card on file.

Card Type: _____ Visa _____ Mastercard _____ Discover _____ AMEX

Last 4 digits of my credit card: _____ _____ _____ _____ Exp. Date (mm/yy): _____ _____

_____ _____

CARDHOLDER'S SIGNATURE DATE

I authorize Parkview Orthopaedic Group, S.C. to charge the credit card indicated on this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above or by your insurance company. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.