

PATIENT REGISTRATION FORM

Patient's name: _____ Nickname: _____ Today's Date: _____

Date of Birth: _____ Age: _____ SS# _____ Gender: Male Female

Mailing Address: _____

City/State/Zip: _____ Apt/Condo# _____

Street Address (If different) _____ E-Mail: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Employer _____ Occupation _____

Hand Dominance: RT LT Preferred Language: English Other: _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino

Race: White Black or African American American Indian Asian Native Hawaiian Other Race

Marital Status: Single Married Widowed Divorced

Communication Preference: Home Phone Cell Phone mail E-Mail

Pharmacy you use: _____ Pharmacy Location: _____

Primary Care Physician: _____

Spouse Information: Name _____ Date of Birth _____

Address (if different) _____ City/State/Zip _____

Employer _____ Work # _____ Ext _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

***Contact methods agreement:** By signing the authorization agreement on the next page, you agree, in order for us to service this account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in charges to you. We may also contact you by sending text messages or emails, using any e-mail address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. **Please initial:** _____

Insurance Information

Primary: _____

Secondary: _____

IS THIS A WORK INJURY? Yes No
IF SO, DID YOU FILE A CLAIM? Yes No
IS THIS IS THIS AN AUTO INJURY? Yes No
IF SO, DID YOU FILE A CLAIM? Yes No

Authorization Agreements (For all patients to complete)

I authorize my medical treatment, billing information and appointment times to be discussed without limitation with the person/people listed below.

Name: _____ Relation: _____ Ok to leave message? Yes No
Name: _____ Relation: _____ Ok to leave message? Yes No
Name: _____ Relation: _____ Ok to leave message? Yes No
Name: _____ Relation: _____ Ok to leave message? Yes No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I received a copy of this office's Notice of Privacy Practices Form, or that one was offered to me.

Patient / Guardian Signature: _____ Date: ____/____/____

(If patient is a minor, please have a parent sign)

Authorization Agreement: I request that payment of authorized health insurance benefits be made on my behalf to Peter T. McAndrews III, D.O., P.C., Justin J. Hollander D.O., P.C., or Eric B. Lerche D.O., PC for any services furnished me. I *understand and agree* that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the doctor to release medical information, including HIV status (if requested) to my insurance company as needed to determine benefits. I also understand that I will be charged a \$35.00 processing fee for any check I write that is returned due to non-sufficient funds. This signature further shows my consent to the contact methods agreement on page one of this form.

_____/_____/_____
Patient or responsible party signature Date

FOR ALL PEDIATRIC PATIENTS & YOUNG ADULTS (up to age 26)

Parent's Information

Mother's Information

Name _____ Date of Birth ____/____/____ SS# _____

Home Address _____ City/State/Zip _____

Employer _____ Address _____

Home Ph# _____ Mobile phone# _____ Work # _____ ext. _____

Father's Information

Name _____ Date of Birth ____/____/____ SS# _____

Home Address _____ City/State/Zip _____

Employer _____ Address _____

Home Ph# _____ Mobile phone# _____ Work # _____ ext. _____

With whom does patient reside? (Check all that apply) Mother Father Joint Custody Other
Who is the guarantor? (Person responsible for bills) Mother Father Self (age 18-26)
Who has legal custody of the child? Mother Father Joint Custody Other

Orthopedic History (page 1)

Name : _____ Date of Birth: _____ Today's date: _____

Chief Complaint

Why are you seeing the doctor today? _____

Briefly describe onset/cause of symptoms: _____

Current problem is the result of a(n): **check** all that apply Date of Injury _____

Car accident Work accident Accident Other

Were you referred here by a physician? No Yes Physician's name: _____

Who is your family doctor? _____ Phone # _____

Review of Systems

Are you currently having or have you had problems with the following (please indicate "yes" even if controlled with medication):

	Circle	Describe all Yes responses, please be specific
Eyes, Ears, Nose, Throat	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Lungs, Breathing Disorders, Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Disease / CHF / MI	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
CVA / Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Numbness / Tingling/ Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Neurological/Psychological Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Depression/Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bleeding Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Gastrointestinal Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Thyroid Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Arthritis / Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Polio / TB / AIDS / Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Skin Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bowel / Bladder Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Kidney Disease / Dialysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Sleep Apnea	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
C-PAP	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
History of MRSA	<input type="checkbox"/> No <input type="checkbox"/> Yes	if yes, date of last nasal swab ____/____/____
Other – please explain	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Patient Name:

DOB:

History (page 2)

Past Medical History:

None

Year:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History – List All (not just orthopedic):

None

Year:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had general anesthesia?

No Yes

Have any problems with anesthesia?

No Yes Describe: _____

Social History

Work in the home Employed (occupation _____) Student Daycare Retired

Single Married Divorced Separated Widowed

Children? No Yes # _____

Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

History of substance abuse? No Yes What? _____

Smoking Status:

Chews Tobacco

Current Occasional Smoker

Former Smoker

Never smoked

Current Every Day Smoker: please select a level...

Heavy (20-30 cigs/day) Moderate (10-19 cigs/day) Light (1-9 cigs/day) Very Heavy (40+ cigs/day)

Alcohol Use: Heavy Moderate Never Occasionally Past Abuse Daily Rare

Tattoos? Location: _____

Piercings? Location: _____

Patient Signature: _____

Date: _____

Reviewed By: _____

Date: _____

Do any other specific activities give you discomfort?

Does your condition interfere with any of the following?

- Daily activities School activities Work activities Recreation or sports activities

Please explain:

Have you previously been evaluated for this condition by:

- Primary care physician Urgent care setting Another orthopedic surgeon Emergency room visit

Please check any treatments that you have tried for your condition.

- Rest
 Ice
 Anti-inflammatory medication (which ones? _____)
 Pain medication
 Cortisone injection
 Immobilization
 Physical Therapy
 Other: _____

Has the treatment helped?

- Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Have you had any other significant injury to this body part in the past?

- Yes No

If yes, please explain:

If yes, did you recover fully? _____

Have you ever had surgery on this area in the past? Yes No

If yes, please explain: (date, doctor, procedure)

Have you had any imaging studies for the injury that we are evaluating you for?

- X-Ray CT Scan MRI Bone Scan Arthrogram Other: _____

Please list any other information you feel would assist your doctor with your treatment:

Patient Signature: _____

Physician Signature: _____

ALLERGY / MEDICATION RECORD

Patient Name: _____ Date of Birth: _____ Date: _____

ALLERGIES

Please List All ALLERGIES and Reactions:

No Known Drug Allergies

Medication	Reaction

Are you allergic to Egg, Egg Products, or Poultry? No Yes Reaction: _____

Are you allergic to Latex? No Yes Reaction: _____

Are you allergic to any Metals? No Yes: _____

Have you ever had a reaction to costume jewelry? No Yes Reaction: _____

Please list any other allergies: _____

PHARMACY YOU USE: _____ PHARMACY ADDRESS: _____

MEDICATIONS

Please list all prescription medications, supplements, and over-the-counter medications you take on a daily basis:

No Medications

Medication	Dosage	Frequency

Patient Signature: _____ Date: _____