

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: \_\_\_\_\_

**TELL ME ABOUT YOUR ORTHOPAEDIC PROBLEM**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Today's date: \_\_\_\_\_

Affected Side: Right (R) or Left (L) or Both (circle one)

1. How would you characterize the onset of your pain?

- R  L  Sudden  
R  L  Gradual  
R  L  Unknown

2. What has the pattern of your pain been?

- R  L  Increasing  
R  L  Decreasing  
R  L  Unchanging  
R  L  Episodic  
R  L  Persistent

3. About how long has this problem hurt you?

- R \_\_\_\_\_  
Any prior injuries to this extremity?  
Yes  \_\_\_\_\_ No   
L \_\_\_\_\_  
Any prior injuries to this extremity?  
Yes  \_\_\_\_\_ No

4. Where exactly is your pain located?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Rate your pain 6 months ago.

- R  none=0 1 2 3 4 5 6 7 8 9 10= severe  
L  none=0 1 2 3 4 5 6 7 8 9 10= severe

6. Rate your average pain over the last week.

- R  none=0 1 2 3 4 5 6 7 8 9 10= severe  
L  none=0 1 2 3 4 5 6 7 8 9 10= severe

7. What best describes your pain?

- R  L  Aching  
R  L  Sharp  
R  L  Throbbing  
R  L  Burning  
R  L  Tingling  
R  L  Intermittent  
R  L  Constant  
R  Other: \_\_\_\_\_  
L  Other: \_\_\_\_\_

8. What aggravates your pain?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. What relieves your pain?

- R  L  Nothing  
R  L  Rest  
R  L  Heat  
R  L  Ice  
R  L  Medication  
R  L  Exercise  
R  L  Modification of activity  
R  L  Topical ointments  
R  L  Lidoderm patch  
R  Other: \_\_\_\_\_  
L  Other: \_\_\_\_\_

Continued on next page

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

10. How would you characterize your pain?

- R  L  An inconvenience  
R  L  More than an inconvenience  
R  L  Disabling

11. What initially brought on your pain?

- R  L  Not sure  
R  L  Trauma  
R  Other: \_\_\_\_\_  
L  Other: \_\_\_\_\_

12. What previous diagnostic tests have you had for this problem?

- R  L  None  
R  L  Plain radiographs  
R  L  MRI  
R  L  CT Scan  
R  L  Bone Scan  
R  L  EMG

13. Note if any of the following have evaluated or treated you for this problem?

- Orthopedic surgeon  
 Neurosurgeon  
 Neurologist  
 Rheumatologist  
 Chiropractor  
 Pain Management  
 Other: \_\_\_\_\_

14. Have you had physical therapy for this problem?

- Yes  (if yes, when) No   
R \_\_\_\_\_  
L \_\_\_\_\_

15. Have you had any previous surgeries on this Area?

- Yes  No   
(if yes, what surgery and when?)  
R \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
L \_\_\_\_\_  
\_\_\_\_\_

16. What medications have you taken?  
(mark a P for those used in PAST)  
(mark C for those used CURRENTLY)

- \_\_\_\_\_ None  
\_\_\_\_\_ Tylenol  
\_\_\_\_\_ Aspirin  
\_\_\_\_\_ Ibuprofen / Motrin  
\_\_\_\_\_ Aleve / Naprosyn  
\_\_\_\_\_ Other NSAID: \_\_\_\_\_  
\_\_\_\_\_ Ultram / Tramadol / Ultracet  
\_\_\_\_\_ Narcotic: \_\_\_\_\_  
\_\_\_\_\_ Glucosamine / Chondroitin  
\_\_\_\_\_ Cortisone injection  R  L  
\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
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: \_\_\_\_\_