



REGIONAL

ORTHOPAEDICS & PAIN MANAGEMENT, PLLC

Name: _____ Date of Birth: _____ Age: _____

SS#: _____ Sex: () Male () Female Marital Status: _____

Name of Parent (if child): _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: Name & Relationship: _____ Phone: _____

Please note when completing information below if patient is a child please provide parent or guardian information:

Occupation: _____ Business Phone: _____

Employed By: _____

Employers Address: _____

INSURANCE INFORMATION

IS THIS CONDITION/INJURY: WORK RELATED? () YES () NO AUTO ACCIDENT? () YES () NO

Primary Insurance: _____ Phone: _____

Policy/ID#: _____ Plan#: _____ Group#: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's Date of Birth: _____

Secondary Insurance: _____ Phone: _____

Policy/ID#: _____ Plan#: _____ Group#: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's Date of Birth: _____

UNIFORM ASSIGNMENT AND RELEASE OR INFORMATION STATEMENTS

I hereby authorize Regional Orthopaedics & Pain Management, PLLC to release any medical information to my insurance company to process my insurance claim. I understand that I am financially responsible for all charges not paid by the insurance company including any and all co-payments, co-insurance, deductibles, collection costs, returned check fee of \$25.00, or attorney fees. I understand that it is my responsibility to inform Regional Orthopaedics & Pain Management, PLLC of any changes in the information on this form.

I assign to Regional Orthopaedics & Pain Management, PLLC sufficient monies and benefits to which I may be entitled from the government agencies, insurance carriers, or others who are financially liable for my medical care, to cover the costs of the care and treatment to me or my dependent.

For patients entitled to Medicare Benefits: I certify that the information given by me in applying for payment under the title XVIII of the Social Security Act is correct. I authorize any holder of my medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized benefits be made on behalf to Regional Orthopaedics & Pain Management, PLLC for services furnished to me by the providers of the group.

Patient's Signature: _____ Date: _____

Print Name: _____ Relationship: _____

If signed by a representative, please print name and relationship to patient above

REGIONAL ORTHOPAEDICS & PAIN MANAGEMENT, PLLC

Date: _____

Name: _____

DOB: _____

I, acknowledge that I received the written Notice of Privacy Practices and Record Disclosure.

- The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone
- Leave message with detailed information
 - Leave message with call back number
- Work Telephone
- Leave message with detailed information
 - Leave message with call back number
- Written Communication
- Can mail to home address
 - Can mail to work address
 - Can fax to this number: _____

I consent to have my personal health information disclosed to my:

- Spouse: _____
- Parent: _____
- Parent: _____
- Other: _____

Signature

PATIENT CLINICAL INFORMATION SHEET



Patient Name: _____

Today's Date _____ Date of Birth _____

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

Allergies (include medication and food allergies)

Surgical History

Hospitalization History (list any hospitalization for reasons other than any surgeries listed above)

Date(s) _____ Reason _____

Date(s) _____ Reason _____

Current Medications (include vitamins and birth control pills, if applicable)

Name of Medication:	Dosage:	Frequency:	Taken for:	Other Information for this medication

Preferred Pharmacy:

Name _____ Location _____

Rx History Consent:

Do you give permission for us to view your prescription history from an external source? ___ Yes ___ No

Patient or Authorized Person Signature: _____

Domestic Situation

With whom do you live? _____

Are there any substance abuse issues in the household? Yes _____ No _____

If yes, please explain _____

Are you able to take care of yourself? Yes ___ No ___ If no, name of caregiver _____

Work History/Status

Are you currently working? _____ If no, please complete the following section:

Job	Years worked	Why did you leave?
_____	_____	_____

Legal Matters

Are you presently involved in a lawsuit? Yes _____ No _____ If yes, please explain:

Substance Use

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you used it:

Occasionally ("O"), Frequently("F"), or Continuously ("C").

Alcohol _____ Barbiturates _____ Cocaine _____

Heroin _____ Amphetamines _____ Marijuana _____

Other _____ Other _____ Other _____

Are you presently using any of the drugs or substances below? (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you use it:

Occasionally ("O"), Frequently("F"), or Continuously ("C").

Alcohol _____ Barbiturates _____ Cocaine _____

Heroin _____ Amphetamines _____ Marijuana _____

Other _____ Other _____ Other _____

Review of Systems

	NO	YES		NO	YES
General/Constitutional			Cardiovascular		
Change in appetite			Chest pain at rest		
Chills			Chest pain with exertion		
Fever			Irregular heartbeat		
ENT			Shortness of breath		
Decreased hearing			Gastrointestinal		
Sore throat			Abdominal pain		
Swollen glands			Diarrhea		
Endocrine			Nausea		
Cold intolerance			Vomiting		
Excessive thirst			Genitourinary		
Heat intolerance			Blood in urine		
Weight loss			Difficulty urinating		
Respiratory			Frequent urination		
Cough			Skin		
Shortness of breath at rest			Dry skin		
Shortness of breath with exertion			Itching		
Wheezing			Rash		
Psychiatric			Neurologic		
Anxiety			Dizziness		
Depressed Mood			Fainting		
Difficulty sleeping			Headache		
Substance Abuse, including alcohol If yes, please explain:			Other condition for any listed system:		

Family History- please complete/check the boxes below

Relative:	Alive/Age	Deceased	Diabetes	Hyper-tension	Heart Disease	Stroke	Cancer	Unknown Or Other <small>(Please explain)</small>
Mother								
Father								

Siblings	# brothers ____ # sisters ____	Healthy? Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If no, please briefly explain:</i>
Children	# sons ____ # daughters ____	Healthy? Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If no, please briefly explain:</i>

Tobacco Use

Do you presently smoke cigarettes or use tobacco in any form? Yes _____ No _____

If current smoker:

How often do you smoke cigarettes: _____ every day _____ some days

How many cigarettes a day do you smoke?:

_____ 5 or less _____ 6 to 10 _____ 11 to 20 _____ 21 to 30 _____ 31 or more

How soon after you first wake up do you smoke your first cigarette?

_____ within 5 minutes _____ 6 to 30 minutes _____ 31 to 60 minutes _____ after 60 minutes

Are you interested in quitting?

_____ Ready to quit _____ Thinking about quitting _____ Not ready to quit

If not a current smoker, did you ever smoke cigarettes or use tobacco in any form? Yes _____ No _____

How many packs (did) you smoke a day? _____ For how many years? _____

Primary Care

To assist us with your care, please provide the name and location of your Primary Care Physician:

Name _____ Location(City/State) _____

Phone Number _____

Would you like us to send the note(s) from today's visit to the above PCP? ____ Yes ____ No

Would you like us to send the note(s) from today's visit to any other provider? If yes, please list name/address:

We appreciate your assistance with obtaining your complete medical history. All of the information contained on this form is part of your confidential medical record with our office. The medical assistant will privately review with you in the exam room during today's visit.