OrthoSports Athens, LLC – Patient Registration Form

Name: _____ Gender: M or F

Date of Birth:____/____/_____ SS#:_____-_____-_____

Mobile #: (____) _____ Work #: (____) _____

Home #: (____) _____ Employer: _____

Your Mailing Address: _____

City : _____ State: _____ Zip: _____

Email Address: _____

Your email address will be used to enable your patient portal account, which will allow you to securely access your health record from your computer or smart phone. Please help us test the system by viewing your record and sending us a test message. Ask a receptionist or nurse if you need help or for more information. Thank you!

Referring Doctor: _____ **Primary Doctor**: _____

Pharmacy Name: _____ **Pharmacy Location**: _____

Your Preferred Contact Method: Text Voice Call *(*If possible)*

Your Preferred Language: Decline English Spanish Other _____

Your Race: Decline Asian Black White Other _____

Your Ethnicity: Decline Hispanic Non-Hispanic Other _____

Marital Status: Single Married Widowed Divorced Other

Spouse Name: _____ Spouse Date of Birth:____/____/____

Emergency Contact: _____ Relationship: _____

Phone #: (____) _____

Responsible Party (**If different from patient**)

Name: _____ Relationship: _____

Date of Birth:____/____/____ SS#:____-____-____

Mobile #: _____ Home #: _____

Address: _____

Please fill this section out if the insurance is not in the patient's name:

Name of Policyholder (as it appears on the card): _____

SS#:____-____-____ DOB:____/____/____ Relationship: _____

How did you hear about us? __Word of Mouth __TV __Magazine __Newspaper __Internet

__Billboard __Referred by Physician __Other/Details _____

I hereby authorize OrthoSports Athens, LLC to furnish and/or receive information concerning my health to my insurance carrier, other physicians, or healthcare facilities involved in my care and hereby assign OrthoSports Athens, LLC all insurance payments for services rendered to me.

I am aware that if I would like a clinical summary after my visits, I can access it electronically through the patient portal, or I can ask to be provided with a paper copy; however, in an effort to reduce paperwork, I will not require a visit summary if I do not ask for it.

I accept financial responsibility for any amounts due to OrthoSports Athens, LLC after insurance has processed my claim. I understand that if a 3rd party is not involved in paying for services rendered to me by OrthoSports Athens, LLC, that I am financially responsible for any monies due to OrthoSports Athens, LLC.

Signature: _____ **Date**: _____

OrthoSports Athens, LLC – History Form

Name: _____ Date: _____

Reason for today's visit: _____

_____,Side: Left or Right

Was it an Accident? YES or NO If yes, **Date of Accident**: _____

Type of accident? WORK HOME AUTO SPORTS OTHER _____

Describe how the accident happened:_____

_____

State in which accident occurred: _____ Is a lawyer involved? YES or NO

Current Medications **Or** ☐**Not currently taking any medication**

* **Please print clearly** Strength Frequency Start & End Date

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

…If there are more, please check here ____ and continue on the back of this sheet

Your Past Medical History (please check below and write in details) **Or** ☐**None**

☐ Heart disease, type _____	☐ High blood pressure	☐ Stroke
☐ Lung disease, type _____	☐ Diabetes	☐ Abdominal problems
☐ Cancer, type _____	☐ Sleep apnea	☐ Gout
☐ Bleeding disorder, type _____	☐ Thyroid problems	☐ Prostate problems
☐ Blood clots, location _____	☐ Hepatitis	☐ Kidney failure
☐ Arthritis, type _____	☐ HIV/AIDS	☐ Unexplained weight loss
☐ Mental illness, type _____	☐ Reflux or Gastritis	

☐ Other_____

Allergies & Any Reactions **Or** ☐**No Known Allergies**

1)_____ 4)_____
2)_____ 5)_____
3)_____ 6)_____

…If there are more, please check here ____ and continue on the back of this sheet

Name: _____

Past Surgical History (please check below and write in details) **Or** ☐**None**

☐ Cancer surgery, type _____ ☐ Appendectomy ☐ Neck surgery, type _____
☐ Back surgery, type _____ ☐ Gallbladder removed ☐ Shoulder surgery, type _____
☐ Heart surgery, type _____ ☐ Hernia repair ☐ Hip surgery, type _____
☐ Joint replacement, type _____ ☐ Gastric bypass ☐ Knee surgery, type _____
☐ Lung surgery, type _____ ☐ Cataract surgery ☐ Fracture surgery, type _____
☐ Female surgery, type _____ ☐ Kidney stone surgery ☐ Carpal tunnel, side: L or R
☐ Bladder surgery
☐ Other _____

Family Medical History Please list any medical problems in your immediate family:

Mom problems: _____ Dad problems: _____
☐Alive or ☐Deceased ☐Alive or ☐Deceased
Their Year of Birth (*required)_____ Their Year of Birth (*required)_____
Siblings problems: _____ Children problems: _____

Social History

Do you smoke? ☐YES or ☐NO If yes, how many_____, for how long: _____
Former smoker? ☐YES or ☐NO Do you live alone? ☐YES or ☐NO
Do you dip tobacco? ☐YES or ☐NO Do you use a cane or walker? ☐YES or ☐NO
Do you drink alcohol regularly? ☐YES or ☐NO Do you have stairs? ☐YES or ☐NO

Review of Systems

Have you recently experienced any of the following symptoms or issues?

Yes	No		Yes	No	
☐	☐	New headache	☐	☐	Nausea or vomiting
☐	☐	Fever	☐	☐	Abdominal pain
☐	☐	Weight loss	☐	☐	Anemia
☐	☐	New visual changes	☐	☐	Fatigue
☐	☐	Toothache	☐	☐	Increased frequency of urination
☐	☐	Nose bleeds	☐	☐	Burning with urination
☐	☐	Temperature Intolerance	☐	☐	Itching
☐	☐	Cough	☐	☐	Rash
☐	☐	Wheeze	☐	☐	Numbness in extremities
☐	☐	Chest pain	☐	☐	Poor balance
☐	☐	Shortness of breath	☐	☐	Depression
☐	☐	Heartburn, uncontrolled	☐	☐	Poor sleep patterns

Any other issues you feel are important to your medical complaint:

_____

_____

_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments when possible. We may do this by telephone, text message, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____

Signature **Date**

OrthoSports Athens, LLC
Authorization to Leave Messages

I give OrthoSports Athens, LLC staff permission to leave detailed messages for me on my answering machine or with the following individuals, and also give permission for my accounting records, insurance information, and/or medical records to be discussed with the following individuals:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

Patient Initials: _____