Huntington Orthopedic Surgical Medical Group

Patient Registration Form

Patient Name: _____ Date of Birth: _____ Sex (M/F) _____
Last First

New Patient ☐ Former Patient ☐ Social Security # _____

Home Phone# (_____) _____ Cell# (_____) _____

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Telephone# (_____) _____

Person to Notify in Case of Emergency: _____

Emergency Contact Relationship: _____ Emergency Phone# (_____) _____

Referring Physician (Physician who sent you to us): _____

Primary Care Physician: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

ID# _____ SSN# _____ Group #/Name _____

Name of Policyholder: _____ Date of Birth: _____ Sex (M/F) _____

Employer: _____

Relationship of Patient to Policyholder: _____

Secondary Insurance Carrier (Billed For Medicare Only): _____

ID# _____ SSN# _____ Group#/Name: _____

Name of Policyholder: _____ Date of Birth: _____ Sex (M/F) _____

Relationship of Patient to Policyholder: _____

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private insurance and any other health plan to Huntington Orthopedics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, Whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Notice of Privacy Practices for Protected Health Information and Acknowledgment of Notice Receipt

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices implemented by this practice and understand that My protected health information may be used by the practice as described in the notice.

Furthermore, for the purposes of continuity of care, I specifically authorize Huntington Orthopedics to communicate my protected health care information with my primary care physician and/or referring physician (s) noted above. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

Signature of Patient or Responsible Party: _____ Date: _____

PRINT CLEAR

HISTORY AND PHYSICAL EXAMINATION II

 CTRMD(04/27/91)

NAME:_____

EMPLOYER:_____ OCCUPATION:_____

TODAY'S DATE:_____ DATE OF INJURY:_____

****

BIRTHDATE:_____ AGE:_____ SEX: ☐ M ☐ F

HANDEDNESS: ☐ R ☐ L RACE:_____

****

HOW DID THE INJURY HAPPEN?:_____

_____

_____

_____

_____

WHAT PART(S) OF YOUR BODY WAS/WERE INJURED?:_____

_____

_____

TO WHOM WAS THE INJURY REPORTED AND WHEN?:_____

_____

WERE YOU ABLE TO CONTINUE WORKING?: ☐ YES ☐ NO

NAME OF THE FIRST DOCTOR YOU SAW AND WHEN:_____

_____

NAME OF THE FACILITY:_____

REFERRED BY?:_____

TYPE OF TREATMENT (medications, splints, supports, physical therapy):_____

_____

_____

WERE YOU PLACED OFF WORK?: ☐ YES ☐ NO

WERE YOU PLACED ON MODIFIED DUTY?: ☐ YES ☐ NO

ARE YOU WORKING NOW?: ☐ YES ☐ NO

REGULAR DUTY?: ☐ YES ☐ NO

MODIFIED DUTY?: ☐ YES ☐ NO - IF YES, DESCRIBE RESTRICTIONS:

_____

LIST ALL DATES OF DISABILITY: _____

_____

HAVE YOU HAD ANY SPECIAL TESTS: ☐ MRI ☐ CAT ☐ SACN ☐ EMG ☐ BONE SCAN

☐ ARTHROGRAM ☐ BLOOD/URINE TESTS ☐ OTHER?: _____

DESCRIBE THE TEST, AREAS OF YOUR BODY TESTED AND DATE OF THE TEST:

_____

_____

ARE YOU CURRENTLY BEING TREATED?: ☐ YES ☐ NO

PLEASE DESCRIBE YOUR CURRENT OR MOST RECENT TREATMENT: _____

DOCTOR(S): _____

_____

NAME OF FACILITY: _____

REFERRED BY: _____

TYPE OF TREATMENT: _____

_____

DATE FIRST SEEN: _____

DATE LAST SEEN: _____

ANY SURGERY FOR CURRENT CONDITION?: ☐ YES ☐ NO

TYPE OF SURGERY, DATE OF SURGERY, AND HOSPITAL: _____

_____

HAVE YOU HAD ANY NEW INJURIES OR REINJURIES?: ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

_____

_____

****

PRESENT SYMPTOMS: PLEASE INDICATE ANY AREAS IN WHICH YOU ARE CURRENTLY STILL HAVING PROBLEMS AND PLEASE COMPLETE THE ATTACHED BODY DRAWING.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

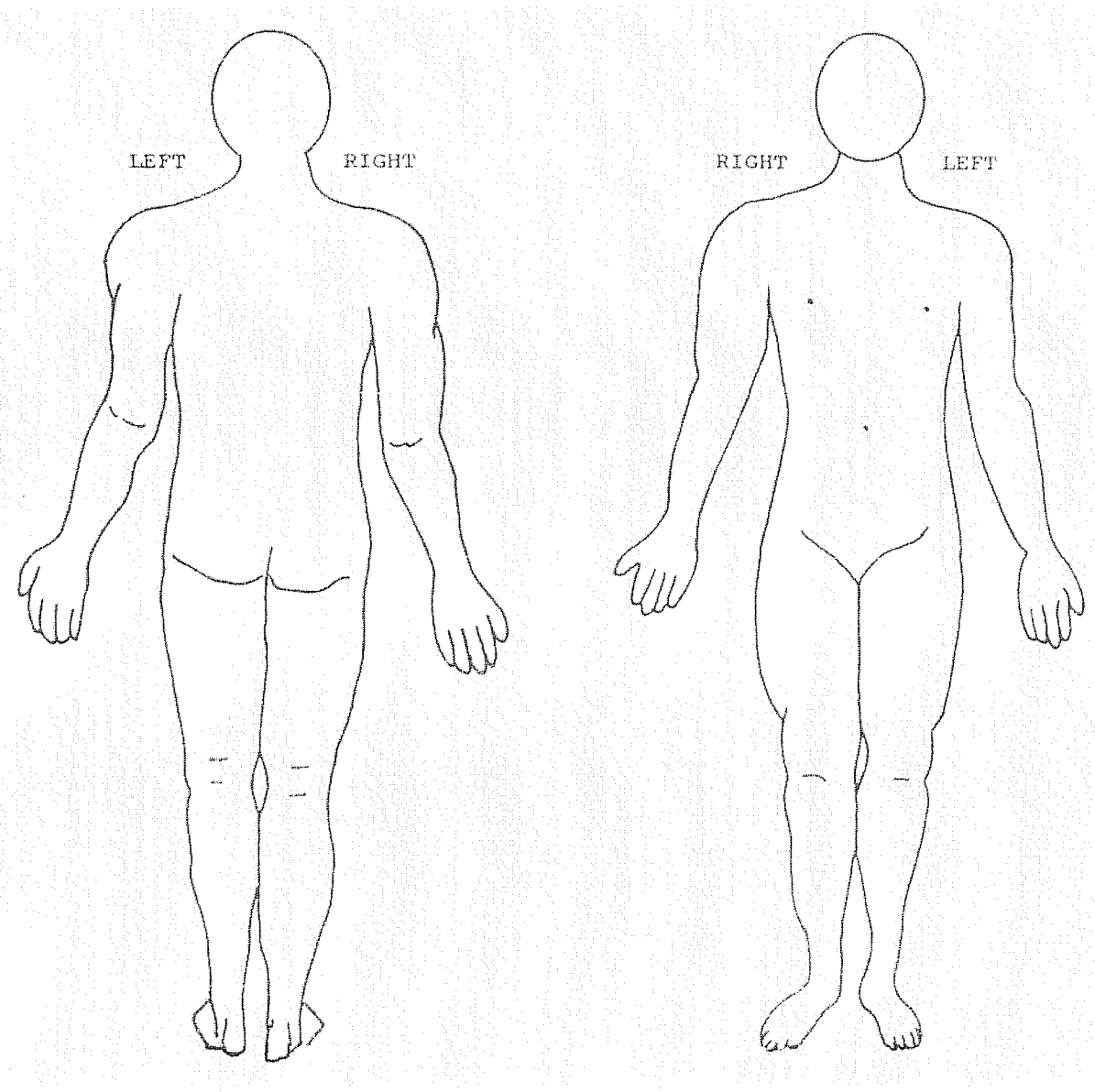
Name_____Age_____Date_____

THIS PICTURE IS TO SHOW WHERE YOU STILL HAVE PAIN OR SYPTOMS, IF ANY, AS A RESULT OF YOUR (WORK) INJURY.

Mark the area on your body where you feel the described sensations. Use the appropriate symbol, and include all of the affected areas.

ACHE	++++	NUMBNESS	----	PINS	0000	BURNING	XXXX
	++++		----	&	0000		XXXX
	++++		----	NEEDLES	0000		XXXX

STABBING ////
////
////



PAST MEDICAL HISTORY

A. MEDICAL: DO YOU HAVE A HISTORY OF: (CHECK IF YES)

☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ KIDNEY DISEASE ☐ DIABETES

☐ TUBERCULOSIS ☐ CANCER ☐ ULCERS ☐ PNEUMONIA

☐ HEPATITIS ☐ EYE PROBLEMS ☐ SKIN PROBLEMS ☐ ASTHMA

☐ ARTHRITIS ☐ RHEUMATOID ARTHRITIS ☐ LUPUS ☐ BLEEDING

☐ OTHER MUSCULOSKELETAL DISEASES ☐ OTHER ENDOCRINE DISEASES

☐ NEUROLOGICAL DISEASES

OTHER: _____

IF YES TO ANY OF THE ABOVE, PLEASE DESCRIBE THE CONDITION:

_____

_____

_____

B. MEDICATIONS: PLEASE LIST ALL MEDICATIONS YO ARE PRESENTLY USING: _____

_____

C. SURGERIES: PLEASE LIST ALL SURGERIES PERFORMED:

SURGERY DATE HOSPITAL/DOCTOR

_____

_____

_____

_____

D. PREVIOUS ACCIDENTS, TRAUMA, INJURIES (SPORTS, CAR OR OTHER MOTOR VEHICLE, MILITARY), OR SIMILAR CONDITIONS: _____

_____

_____

DUE TO THE NATURE OF YOUR CLAIM, PLEASE COMPLETE THE FOLLOWING:

HAVE YOU HAD ANY PRIOR INJURIES OR PROBLEMS WITH THE CURRENTLY INSURED AREA(S)?: ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

PLEASE DESCRIBE ALL OTHER PRIOR INDUSTRIAL OR NON-INDUSTRIAL INJURIES (IF NOT DESCRIBED ABOVE). PLEASE NOTE IF THIS OR THESE INJURIES ARE WORK OR NOT WORK-RELATED, DATE OF INJURY, AREAS OF YOUR BODY WHICH WERE INJURED, IF YOU HAVE RECOVERED OR HAVE HAD ONGOING PROBLEMS AND IF YOU HAVE ANY PERMANENT DISABILITY. _____

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ALLERGY:

MEDICATIONS: _____

FOODS: _____

OTHER (SKIN TAPE, HAY FEVER): _____

****

FAMILY HISTORY:

MOTHER: AGE:_____ ☐ LIVING AND WELL ☐ DECEASED AND DUE TO:

_____

LIVING WITH THE FOLLOWING MEDICAL CONDITIONS:_____

_____

FATHER: AGE:_____ ☐ LIVING AND WELL ☐ DECEASED AND DUE TO:

_____

LIVING WITH THE FOLLOWING MEDICAL CONDITIONS:_____

_____

BROTHERS AND SISTERS: NUMBER OF BROTHERS:_____

NUMBER OF SISTERS:_____

NUMBER LIVING:_____

NUMBER DECEASED:_____

ANY MEDICAL CONDITIONS?:_____

_____

****

SOCIAL HISTORY:

STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

CHILDREN: NUMBER:_____ AGES:_____

HABITS: CIGARETTES/SMOKE: ☐ YES ☐ NO HOW MUCH/HOW LONG:_____

CONSUME ALCOHOL: ☐ YES ☐ NO HOW MUCH:_____

HOBBIES:_____

****

ROS (FOR THE PHYSICIAN TO FILL OUT):_____

_____

WORK HISTORY:

DUE TO THE NATURE OF YOUR INJURY, PLEASE COMPLETE THE FOLLOWING REGARDING YOUR WORK HISTORY.

CURRENT EMPLOYER:_____

JOB TITLE:_____

DATE HIRED:_____

JOB DUTIES:_____

_____

_____

PLEASE LIST YOUR LAST THREE OR MOST RECENT EMPLOYERS.

1. EMPLOYER:_____

   JOB TITLE:_____

   DUTIES:_____

   DATES EMPLOYED:_____

2. EMPLOYER:_____

   JOB TITLE:_____

   DUTIES:_____

   DATES EMPLOYED:_____

3. EMPLOYER:_____

   JOB TITLE:_____

   DUTIES:_____

   DATES EMPLOYED:_____

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PRINT CLEAR FORM