PATIENT REGISTRATION FORM

Patient's name**:** _____ Preferred Name: _____Today's Date:

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

Mailing Address: _____

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

Street Address (If different) _____

E-Mail: _____ ☐ Yes, please activate a patient portal account using this email address

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: _____We will be sending copies of any treatment we provide

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: _____

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

Secondary: _____

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	☐No	☐Yes	_____
Lungs, Breathing Disorders, Asthma	☐No	☐Yes	_____
High Blood Pressure	☐No	☐Yes	_____
Heart Disease / CHF / MI	☐No	☐Yes	_____
Heart Murmur	☐No	☐Yes	_____
CVA / Stroke	☐No	☐Yes	_____
Numbness / Tingling/ Paralysis	☐No	☐Yes	_____
Neurological/Psychological Disorder	☐No	☐Yes	_____
Depression/Anxiety	☐No	☐Yes	_____
Bleeding Disorders	☐No	☐Yes	_____
Gastrointestinal Disorders	☐No	☐Yes	_____
Cancer	☐No	☐Yes	_____
Thyroid Disease	☐No	☐Yes	_____
Diabetes	☐No	☐Yes	_____
Arthritis / Osteoporosis	☐No	☐Yes	_____
Polio / TB / AIDS / Hepatitis	☐No	☐Yes	_____
Skin Disorders	☐No	☐Yes	_____
Bowel / Bladder Disorders	☐No	☐Yes	_____
Kidney Disease / Dialysis	☐No	☐Yes	_____
Sleep Apnea	☐No	☐Yes	_____
C-PAP	☐No	☐Yes	_____
History of MRSA	☐No	☐Yes	if yes, date of last nasal swab _____/_____/_____
Other – please explain	☐No	☐Yes	_____

Patient Name: **DOB:** **History (page 2)**

Past Medical History: ☐ **None** Y**ear:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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: _____

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:** _____