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: _________________________________

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., Eric B. Lerche D.O., PC or West Bay Foot & Ankle, PLLC 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. In order to determine benefits, I authorize the doctor or his mid-level provider to release all medical information, including my full medical history, surgical history & HIV status (if requested) to the insurance company(ies) being billed. 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 and that I have reviewed or was offered the financial policy.

____ ____/____/______

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** 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 __Disabled __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: ______________