

**ORTHOPEDIC AND NEUROSURGICAL SPECIALISTS, LLC.**

**Patient Registration**

**PATIENT INFORMATION**

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: (circle) M F  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE INFORMATION:** Fill in for each Ins. Co. (Circle type and Show ID Cards to Receptionist)

**Insurance #1** Type: Health Auto Workers' Comp. Date of accident for Auto or WC: \_\_\_\_\_  
Ins Co Name \_\_\_\_\_ Subscriber's Name \_\_\_\_\_  
Ins Policy/ID # \_\_\_\_\_ Subscriber's SSN# \_\_\_\_\_  
Ins Group/Claim # \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_\_

**Does your plan require referrals?** Yes No

**Insurance #2** Type: Health Auto Workers' Comp. Date of accident for Auto or WC: \_\_\_\_\_  
Ins Co Name \_\_\_\_\_ Subscriber's Name \_\_\_\_\_  
Ins Policy/ID # \_\_\_\_\_ Subscriber's SSN# \_\_\_\_\_  
Ins Group/Claim # \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_\_

**Does your plan require referrals?** Yes No

**PATIENT'S FAMILY DOCTOR**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

**Who referred you to our office?**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_  
Phone \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Name \_\_\_\_\_ Phone # \_\_\_\_\_

# HEALTH HISTORY INFORMATION

## PAST MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following?

- |                                   |  |   |   |
|-----------------------------------|--|---|---|
| <input type="checkbox"/> Heart    | <input type="checkbox"/> Blood Pressure (high / low) | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Lungs    | <input type="checkbox"/> Diabetes (Insulin? Y / N )  | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Liver    | <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Kidney   | <input type="checkbox"/> Psoriasis                   | <input type="checkbox"/> Blood Clots        | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> Ulcers   | <input type="checkbox"/> Cancer (Where? _____)       | <input type="checkbox"/> Psychiatric        | <input type="checkbox"/> HIV/AIDS         |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Infections                  | <input type="checkbox"/> Thyroid Disease    |   |

## REVIEW OF SYSTEMS

Have you been in good health lately? (circle) Yes No                      Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you currently experiencing a problem with any of the following:

Eyes	Yes	No		Muscularskeletal	Yes	No
Ears/Nose/Mouth/Throat	Yes	No		Integumentary (Skin, Breast)	Yes	No
Cardiovascular	Yes	No		Neurological	Yes	No
Respiratory	Yes	No		Psychiatric	Yes	No
Gastrointestinal	Yes	No		Endocrine	Yes	No
Hematological/Lymphatic	Yes	No		Genitourinary	Yes	No
Allergic/Immunologic	Yes	No		Other _____		

If you answered yes, please explain each problem. \_\_\_\_\_

Do you have a history of

osteoarthritis?                      Yes    No

rheumatoid arthritis?    Yes    No    If yes, duration \_\_\_\_\_

Do you have any shortness of breath, cough, breathing problem?    Yes    No

Have you had

any recent weight gain or loss?                      Yes    No    If yes, explain. \_\_\_\_\_

any hearing or vision problems?                      Yes    No    If yes, explain. \_\_\_\_\_

any bowel or bladder problems?                      Yes    No    If yes, explain. \_\_\_\_\_

Have you or anyone in your family had bleeding problems?    Yes    No

Are there any diseases the run in the family?    Yes    No

If yes, please list. \_\_\_\_\_

Are you right or left handed?    Right    Left

Do you smoke?    Yes    No    If Yes, how often? \_\_\_\_\_

Describe your alcohol use:    Heavy    Moderate    Social    None

## HEALTH HISTORY INFORMATION (continued)

### MEDICATIONS

Do you currently take...

an anti-coagulant medication? (Coumadin, Warfarin, Lovenox, Heparin, Plavix)	Yes	No
a low-dose aspirin (325mg or less) per day?	Yes	No
any oral corticosteroids? (i.e. Prednisone)	Yes	No
any anti-inflammatory medication?	Yes	No

List all current medications including prescription, over-the-counter, and herbal medications: \_\_\_\_\_

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### ALLERGIES

Are you allergic to any medications? Yes No If yes, please list: \_\_\_\_\_

Please list any other relevant allergies (i.e. latex, metals) \_\_\_\_\_

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### SURGERY

Have you had any blood transfusions in the past? Yes No

Have you ever had surgery? Yes No

If yes, please list starting with the most recent surgery.

Date	Type Of Surgery	Type of Anesthesia	Problems/Complications
		Local General	
		Local General	
		Local General	
		Local General	
		Local General	
		Local General	

## DESCRIPTION OF PROBLEM, ACCIDENT OR INJURY

(Information is required to obtain your insurance benefits)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

What is your current work status?    Employed    Unemployed    Student    On Disability    Retired

Current Employer \_\_\_\_\_ Nature of work \_\_\_\_\_

Date of Injury \_\_\_\_\_ Date you first noticed symptoms \_\_\_\_\_

Is your problem a result of an accident?    Yes    No

If yes, where did it happen?    Home    Work    Motor Vehicle    Other \_\_\_\_\_

Please describe your injury including what part of your body is injured and specifically how and where you were injured  
\_\_\_\_\_  
\_\_\_\_\_

Do you have an attorney for this injury? If yes please list the name, address, and phone #.

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

## MEDICAL RELEASE AUTHORIZATION

(This form complies with the HIPPA Privacy Rule)

**I hereby authorize:** Orthopedic & Neurosurgical Specialists, LLC and any of its affiliated practices

**To disclose the following protected health information to:** (office use only)

Physician/Practice Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please indicate the information or types of information to be disclosed:** All medical records in my ONS chart.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above-named facility authorized to make this disclosure. I understand that revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, INITIAL HERE:** \_\_\_\_\_

## **ASSIGNMENT OF BENEFITS**

I hereby authorize release of my protected health insurance information necessary only for the processing of my claims and authorize payment by my insurance carrier directly to Orthopedic & Neurosurgical Specialists, LLC. I understand that bills are submitted to my insurance company on my behalf as a courtesy.

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney, or another physician's office. I hereby authorize direct payment of medical/dental and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and any other health plan to Orthopedic & Neurosurgical Specialists, LLC, and any of its affiliated practices. **I am financially responsible for all charges whether or not paid by insurance.**

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

### **Notice to Patients Regarding Referrals**

It is the patient's responsibility to get referrals from your family physician. Some insurance companies require patients to have referrals before they have a consultation, procedure, follow-up visit after procedures or office visits. Your insurance company made this policy, we are simply asking you to make sure you have your referrals prior to any healthcare services being rendered.

Also, please note the expiration date of your referral. If your referral has expired, it will be your responsibility to obtain a new referral and not the responsibility of this office. Unfortunately, insurance companies will not let the family doctors backdate a referral. Therefore, if you would still prefer to be seen without a referral, the option will be for you to pay for the entire visit at the time of service.

We regret any inconvenience that this referral policy may cause you. However, we are required by the law to abide by the regulations your insurance company has mandated. Thank you for your cooperation with this insurance issue.

### **HIPAA PRIVACY PRACTICES**

I acknowledge that I have received Orthopedic & Neurosurgical Specialists' Notice of Privacy Practices.

**Your signature below indicates you have read each of the above: (Assignment of Benefits, Referral Notification, and HIPAA Privacy Practices).**

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Narcotic Analgesic Agreement

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Dear Patient,

The surgeons at **Orthopedic and Neurosurgical Specialists, LLC** and our staff welcome you to our practice. We recognize that patients with orthopedic problems who come to our office are here for management of an orthopedic condition of one type or another, which may cause varying degrees of pain. Our goal is to help serve you in the best manner that we can.

Some of the conditions, which we treat, will require physical therapy and some medication for pain relief. Some conditions will require surgical intervention and postoperative pain management.

There are times when we will need to prescribe narcotic analgesics or other controlled substances to help you in managing your acute pain. We require a complete disclosure from you regarding which doctors you treat with and what type of other pain medications you have been prescribed. This is for your safety. If it is discovered at any time during your treatment with us that you are receiving a controlled substance for pain relief from another physician, we will no longer prescribe pain medication for you. This is not something we would like to do and we stress the importance of your compliance with our practice regarding pain medication. We have specific extension for medication renewals and requests will be addressed within the week. Medications can only be renewed during normal business hours Monday through Friday.

If you require long-term pain management, appropriate referral back to your primary care physician or pain management specialists will be made. You are responsible for your medication. If it is lost or stolen, or you have taken more than prescribed for certain amount of time, your prescription **will not be refilled**.

Sincerely,

The physicians at **Orthopedic and Neurosurgical Specialists, LLC**

**I acknowledge and agree to the above contract.**

Signature \_\_\_\_\_ Date \_\_\_\_\_