

North Phoenix Orthopedic Surgeons, Ltd.

NEW PATIENT REGISTRATION

PATIENT INFORMATION:

Last Name _____
First Name _____ MI _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
DOB _____ SS# _____
E-mail _____
Primary Care Physician _____
PCP Phone _____
Employer _____
Employer Phone & Address _____

RESPONSIBLE PARTY:

_____ Check, if same as patient

Last Name _____
First Name _____ MI _____
Relationship to Patient _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
DOB _____ SS# _____
E-mail _____
Employer _____
Employer Phone & Address _____

EMERGENCY CONTACT:

_____ Check, if same as responsible party

Last Name _____ First Name _____ MI _____
Relationship to Patient _____ Home Phone _____ Work Phone _____

AUTHORIZED REPRESENTATIVE:

Last Name _____ First name _____ MI _____
Address _____

I authorize the disclosure of my protected health information to my authorized representative for the following purposes (Check only one):

- _____ Disclose all of my claims and information regardless of dates of service, provider or diagnosis.
_____ Do not disclose anything without additional written consent from me.

Signature _____ Date _____ (Required by law)

INSURANCE INFORMATION:

Primary Insurance _____ Secondary Insurance _____
Policy Owner _____ Policy Owner _____
Policy Number _____ Policy Number _____
Group Number _____ Group Number _____
Address _____ Address _____

HIPPA: I have received and read the Notice of Privacy Practices.

Signature: _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize North Phoenix Orthopedic Surgeons to release my medical information necessary to process insurances claims relating to the medical care rendered by North Phoenix Orthopedic Surgeons.

Signature: _____ Date _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to North Phoenix Orthopedic Surgeons for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date _____

CANCELLATIONS: As a recent change in office policy, patients that cancel their appointment must provide a 24 hour notice prior to their scheduled appointment time. Failure to do so may result in a charge of \$35.00 to their account. This procedure has been created with the patient and their families needs in mind. _____ Initials

NORTH PHOENIX ORTHOPEDIC SURGEONS

Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ Height _____ Weight _____ Sex: Male/Female

Who referred you? _____

Primary Care Physician Name _____

Body part being treated today (please check):

___ Right ___ Left

___ Knee ___ Shoulder ___ Hip ___ Ankle ___ Elbow ___ Other(describe) _____

Date of injury: _____ How Did it Occur? _____

Work Related? Y or N

PLEASE CHECK ONLY SIGNIFICANT PROBLEMS:

Pain Problems:		Other Problems:	
___ Aching	___ Electrical	___ Popping	___ Numbness
___ Burning	___ Sharp	___ Stiffness	___ Giving Away
___ At Night	___ Periodic	___ Swelling	___ Grinding
___ During Activity	___ Shooting	___ Weakness	___ kneeling/squatting
___ After Activity	___ Spasmodic	___ Locking	___ Twisting/Turning
___ Tingling	___ Throbbing	___ Limited Motion	___ pain with stairs

Daily medication, name and dosage: Please list _____

Drug Allergies and Reactions: _____

Pharmacy name and phone number: _____

Previous Surgeries:

Type of surgery	Date of surgery

Past Medical History/Family History

<i>Past Medical History</i>	<i>Self</i>	<i>Family</i>		<i>Self</i>	<i>Family</i>
Heart problem/Chest Pain			Arthritis		
High Blood Pressure			Blindness		
Asthma/Shortness of Breath			Thyroid Problems		
Emphysema			Kidney		
Pneumonia			Incontinence		
Diabetes			Cancer		
Anemia/Bleeding disorder			HIV/AIDS		
Stroke			Hepatitis		
Sleep apnea			Deafness		

Social History:

Occupation: _____ Required Lifting? y/n

Marital Status: Single, married, widowed, divorced

Do you smoke? Y/N How much? _____

Alcohol: None /Social / Daily

Hand Dominant? Right/ Left

Are you Pregnant? Y/ N