

# THE ORTHOPEDIC GROUP, PC

## PATIENT REGISTRATION

### PERSONAL INFORMATION

FIRST NAME	MI	LAST NAME
ADDRESS		
CITY		
STATE	ZIP CODE	HOME PHONE NUMBER (     )
WORK PHONE NUMBER (     )	CELL PHONE NUMBER (     )	
E-MAIL ADDRESS		
DATE OF BIRTH	AGE	SEX - M or F
SOCIAL SECURITY NUMBER		
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
PATIENT'S EMPLOYER		OCCUPATION
STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		
BEST TIME TO REACH YOU:	MAY WE CONTACT YOU AT WORK:	
STUDENT STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		
SCHOOL NAME		
SPOUSE'S NAME		
SPOUSE'S SOCIAL SECURITY NUMBER		
SPOUSE'S EMPLOYER	OCCUPATION	PHONE NUMBER (     )
YOU WERE REFERRED BY:		
YOUR FAMILY DOCTORS' NAME IS:		PHONE NUMBER (     )

### PRIMARY HEALTH INSURANCE

INSURED'S NAME (EXAMPLE: SELF, SPOUSE, OR PARENT'S NAME)	
NAME OF INSURANCE COMPANY	
INSURED'S EMPLOYER	
ID NUMBER	GROUP NUMBER
COPAY AMOUNT	INSURED'S BIRTHDATE
RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	

### SECONDARY HEALTH INSURANCE

INSURED'S NAME	EMPLOYER
NAME OF INSURANCE COMPANY	
ID NUMBER	GROUP NUMBER
COPAY AMOUNT	INSURED'S BIRTHDATE
RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	

Name or parent/guardian if patient is a Minor \_\_\_\_\_

### PLEASE READ, SIGN, AND DATE:

I request that payment of authorized Medicare/other insurance benefits be made on my behalf to THE ORTHOPEDIC GROUP, PC for any services furnished me by physician or supplier. I authorize the release of my medical information to the Centers for Medicare & Medicaid Services and/or my insurance company and its agents; any information needed to determine these benefits/benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as co-payments and deductibles.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PHARMACY NUMBER

### EMERGENCY CONTACT:

NAME	RELATIONSHIP
HOME PHONE NUMBER (     )	WORK NUMBER (     )

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Conditions	Treatment

**PAST SURGICAL HISTORY:** Please list any previous surgeries or hospitalizations:

Surgery/Hospitalization	Date	Doctor/Surgeon	Hospital	Complication

Have you ever had general anesthesia? YES NO

Have you ever had any problems with anesthesia? YES NO If yes, describe: \_\_\_\_\_

**MEDICATIONS:** Please list any medications you are currently taking, including vitamins and herbal supplements:

Medication	Dosage/Frequency	Reason for Medication	Date Medication Started	Who Prescribed Medication?

**HAVE YOU EVER TAKEN ANY TYPE OF ANTI-INFLAMMATORY MEDICATION?** YES NO

If YES, Please list the medication, when taken, why taken, and any complications or side-effects:

Patient Initials/Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_



Name \_\_\_\_\_ Date \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Who referred you? \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

What are your current symptoms? \_\_\_\_\_

Precipitating Event? \_\_\_\_\_ When? \_\_\_\_\_

Pain at worst on 0-10 Scale \_\_\_\_\_ Least pain on 0-10 Scale \_\_\_\_\_

What makes your pain better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Have you been seen by another physician or therapist for this problem?

NO \_\_\_\_\_ If YES by whom? \_\_\_\_\_

Review of systems:

Circle if you have: Fever, chills, night sweats, vision changes, rashes, weakness  
Chest pain, shortness of breath, depression, anxiety, swelling in arms or legs  
Headache, numbness, tingling, bowel or bladder changes  
None of the above

### PAIN INTENSITY RATING

On the line below, CIRCLE your AVERAGE PAIN over this last week

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Where is your pain now?

Use appropriate symbols shown below to mark the areas on your body where you feel the described sensations. Include ALL areas affected by your pain and mark the type and area of pain if it radiates or spreads to other areas.

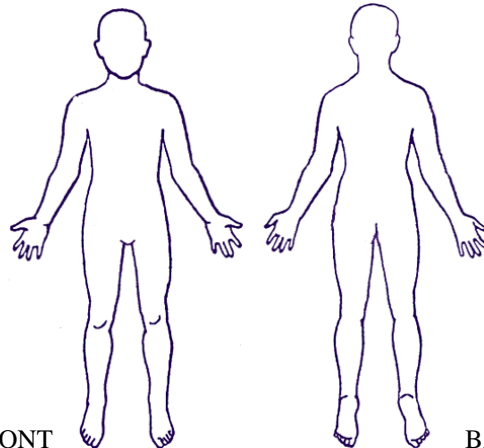
BURNING  
XXXX

NUMBNESS  
OOOO

PINS &  
NEEDLES

STABBING

ACHE



# The Orthopedic Group, P.C.

## Acknowledgment of Receipt of Notice of Privacy Practices

I, X (print name) hereby acknowledge that on the date set forth below, I have received The Orthopedic Group, P.C.'s Notice of Privacy Practices.

### SIGNATURE

Date: X Time: \_\_\_\_\_ AM/PM

Signature: X  
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient:

\_\_\_\_\_

For more information about your privacy rights, please see our "Notice of Privacy Practices" available on our website at [www.TheOrthopedicGroup.com](http://www.TheOrthopedicGroup.com), call our Privacy Officer at 724-379-5816, or send a written request to Privacy Officer, The Orthopedic Group, P.C., 800 Plaza Drive Suite 240 Belle Vernon, PA 15012

If you believe your privacy rights have been violated, you may file a complaint with The Orthopedic Group, P.C. or with the Secretary of the Department of Health and Human Services. To file a complaint with The Orthopedic Group, P.C. write to: Privacy Officer, The Orthopedic Group, P.C., 800 Plaza Drive Suite 240 Belle Vernon, Pa 15012 All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

### Good Faith Efforts to Obtain Acknowledgment of Receipt of Notice

*(For office use only when efforts to obtain acknowledgment of receipt of notice are unsuccessful)*

The notice was provided via (choose one)

- Offered copy and individual accepted delivery  
 Offered copy and individual declined delivery  
 Other (explain)

\_\_\_\_\_  
\_\_\_\_\_

Efforts to Obtain signature on acknowledgment of notice form (choose one)

- Patient or Personal Representative was asked to sign form and refused.  
 Other (explain)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of office personnel

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name