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
□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

PATIENT'S EMPLOYER OCCUPATION

STATUS:
□ FULL TIME □ PART TIME

BEST TIME TO REACH YOU: MAY WE CONTACT YOU AT WORK:

STUDENT STATUS:
□ FULL TIME □ 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
( )

PHARMACY NUMBER

EMERGENCY CONTACT:

NAME RELATIONSHIP

HOME PHONE NUMBER WORK 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:
□ SELF □ SPOUSE □ PARENT □ OTHER

SECONDARY HEALTH INSURANCE

INSURED'S NAME EMPLOYER

NAME OF INSURANCE COMPANY

ID NUMBER GROUP NUMBER

COPAY AMOUNT INSURED'S BIRTHDATE

RELATIONSHIP TO PATIENT:
□ SELF □ SPOUSE □ PARENT □ 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: _____

The Orthopedic Group, PC **Today's Date:**

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:_____

ALLERGIES: Please list any medications your are allergic to:

_____

_____

SOCIAL HISTORY: Are you employed? YES NO If yes, list your occupation: _____

Retired: YES NO Since when? _____ Previous Occupation: _____

Student: YES NO Where? _____

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Separated ( ) Divorced

Number of children: _____ List their ages: _____

Who lives at home with you? _____

What regular exercise or sports do you participate in? _____

_____

What are your hobbies? _____

HABITS:

Question	YES	NO	What type?	If yes, how much?	If stopped using, when & how much?
Do you use tobacco in any form?					
Do you drink alcohol?					
Do you have a history of substance abuse?					

FAMILY HISTORY:

What diseases or conditions exist in your immediate family? (mother, father, sister, brother)

_____

_____

Does anyone in your family have cancer?

_____

_____

Patient Signature: _____ Date: _____

Reviewed/ Updated By:																					
Date:																					

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

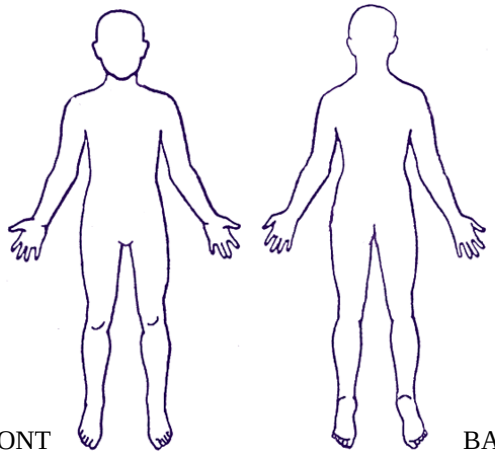
No Pain Worst Possible

0 1 2 3 4 5 6 7 8 9 10

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



FRONT BACK

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, 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