PATIENT REGISTRATION FORM

Patient Name (first, middle, last): ____

Date of Birth: ______________ Age: ______ Male Female Social Security #: ________________ Marital Status: ____________

Mailing Address: ______________________________________ City: _______________________ State: ____ Zip Code: ____________

Physical Address (if diff from mailing): ______________________________ City: __________________ State: ____ Zip Code: _______

Home Phone: _____________________ Cell Phone: _____________________ E-mail: _______________________________________

Referred By: ____

Patient's School: ____ Patient's Coach: _______________________________

Patient's Employer: ____ Work Phone: __________________________

Employer's Address: _____________________________________ City: _______________________ State: _____ Zip Code: _________

Emergency Contact: ____ Emergency Relationship: _______________________________

Emergency Phone: ______________________________________

RESPONSIBLE PARTY/PARENT/GUARDIAN: Person responsible for payment today and after insurance payment (if any).

Name: ____ Date of Birth: ________________ SS #: ________________________

Address: ____ City: _____________________ State: _____ Zip: ____________

Phone Number: _____________________________

INSURANCE INFORMATION:

Do you have school insurance? Yes No

Primary Insurance Company: ___________________________________ Subscriber's Name: ______________________________________

Subscriber's SS #: ______________________________ DOB: ____________________ Employer: ___________________________________

Policy Number: ____ Group Number: ___________________________________

Secondary Insurance Company: ___________________________________ Subscriber's Name: ____________________________________

Subscriber's SS #: ______________________________ DOB: ____________________ Employer: ___________________________________

Policy Number: ____ Group Number: ___________________________________

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician: ____

Address: ____ City: _________________________ State: ________ Zip: _____________

Phone Number: __________________________________ Do you want records sent to your PCP? ☐ Yes ☐ No

MEDICAL CONSENT: I consent to the examination, treatment and procedures which may be performed during the office visit, including emergency treatment considered necessary by the physician. If an invasive procedure is necessary, a specific consent form will be discussed with me at that time.

FINANCIAL POLICY AND CONSENT: Payment of deductibles and copayments is expected at the time of service. I understand that I am responsible for the balance owed to Margaret R. Pardee Memorial Hospital (Pardee) after my insurance carrier(s) have been billed. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any insurance carrier, unless prohibited by law or contract. I consent to Pardee's use and disclosure of my health information to any person or organization that is legally or contractually responsible for payment of my bills for the services I received. I also consent to Pardee's disclosure of my health information to attending and consulting providers for billing purposes.

Signature: ____Date:________________

PATIENT NAME____DOB________________DATE______________

REASON FOR VISIT

REASON FOR VISIT: ____

When did this problem begin (include date/time if accident and location: ____

Describe how injury occurred: ____

Have you had this problem before? YES NO Current Height: _______________ Current Weight: _______________

PLEASE CHECK IF YOU HAVE EVER BEEN TREATED BY: _____Dr. Maxwell _____Dr. Motley _____Dr. Rudins _____Dr. Jones _____ Dr. Phelps _____Dr. Kersten _____Dr. Das

REVIEW OF SYSTEMS

Circle all that apply to you.

Constitutional
Chills
Fatigue
Fever
Malaise
Night sweats
Weakness
Weight gain
Weight loss

HEENT
Blurred Vision
Double Vision
Dysphagia
Ear drainage
Facial pain
Headache
Hearing loss
Hoarseness
Nasal Congestion
Ringing in the ears
Vertigo
Vision Loss

Respiratory
Chest pain
Cough
Dyspnea
Recent infections
Known TB exposure
Wheezing

Cardiovascular
Chest pain
Cyanosis
Heart murmur
Leg Swelling
Syncope
Irregular heartbeat/palpitations

Gastrointestinal
Abdominal Pain
Constipation
Black tarry stools
Diarrhea
Heartburn
Jaundice
Loss of appetite
Nausea
Vomiting

Genitourinary
Dysuria
Frequent urination
Hematuria
Urge incontinence
Urinary incontinence

Metabolic/Endocrine
Cold intolerant
Hair loss
Heat Intolerant

Neurological
Difficulty walking
Dizziness
Poor coordination
Memory loss
Muscle weakness
Paresthesia
Seizures
Tremors

Psychiatric
Anxiety
Depression
Insomnia

Integumentary
Contact allergy
Itchy skin
Rash
Skin infections
Skin lesions

Musculoskeletal
Back Pain
Bone/Joint Symptoms
Myalgia
Muscle Weakness
Neck Stiffness
Rheumatologic Manifestation
Arthritis

Hematologic
Bleeding
Bruising

Immunological
Asthma
Bee Sting allergies
Contact dermatitis
Environmental allergies
Food allergies
Seasonal allergies

Using the diagram please indicate where your current pain is located.

DRAW YOUR PAIN:

Numbness ====
Burning XXXX
Stabbing ////
Pins and Needles OOOO

PATIENT NAME____DOB_________________DATE_______________

PATIENT PHARMACY INFORMATION

Pharmacy Name: ____ Phone Number: ________________________________

Address: ____ City: __________________________ State: ________ Zip: _____________

MEDICATION LIST		
TYPE OF MEDICATION	**DOSAGE**	**REASON FOR MEDICATION**

WORK INFORMATION

What is your job? ____

What are the physical requirements of your job? ____

Is your problem job-related? Y N

If yes, have you notified your employer? Y N

If yes, does your supervisor or boss support you in your treatment? Y N

If yes, have you been offered alternate light duty? Y N

If out of work, how long?

SOCIAL HISTORY

Do you use tobacco ☐YES ☐ NO If yes, how much per day? _____ Do you drink alcohol? ☐YES ☐ NO If yes, how much per day? ______

Do you drink caffeinated beverages? ☐YES ☐ NO If yes how much per day? ______

Please check if you have a history of ☐ excessive alcohol use ☐ excessive prescription drug use ☐ illegal drug use

If so, when? What type of substance?

PAST TREATMENTS FOR CURRENT PROBLEM:

____

____

ALLERGIES		SURGERIES	
TYPE	**REACTION**	**TYPE**	**YEAR**

CURRENT/PAST MEDICAL CONDITIONS	FAMILY HISTORY OF ILLNESS	
	TYPE	**RELATIVE**

PATIENT NAME____DOB________________DATE______________

HIPAA DISCLOSURE INFORMATION: (who we can release to or who can request your medical information)

Who is filling this out?: __________ Patient __________ Guardian

The physician/practice may use or disclose the following protected health information: ☐ The entire medical record or ☐Other:____________
____

The following protected health information is specifically excepted from disclosure: ☐ Nothing or List any health information you do not wish to be disclosed:____

Disclosure to:__________ any health care provider or facility   Others:____

_________ Spouse Name: ________________________________

_________ Children Name(s): ____

MEDICATION/PRESCRIPTION REFILL POLICY

- Please call 24 to 48 hours BEFORE you are out of medication. There will be no exceptions.
- Please leave the following information for your refill. Patient name, Physician name, medication name, and preferred pharmacy.
- Refills require 48 hours. Please check with your pharmacy before calling back AFTER 48 hours.
- No early Refills. No refills on holidays, weekends, or after hours. NO EXCEPTIONS.
- Lost or Stolen medications will not be refilled. NO EXCEPTIONS

XRAY POLICY

If you are a New Patient or being referred by another doctor you need to make sure ALL of your X-Rays are in our office or you are bringing them with you to your appointment.
If you're scheduled for an MRI you will also need to make sure your films are delivered here or you need to pick up a copy and bring them with you to your appointment. It is your responsibility to make sure your films are here. If you do not check and your films are not here you will not be seen that day.

Explanation/Findings of X-rays and MRIs

To assist your physician in fully explaining the results of your diagnostic x-rays or MRIs, your physician may show you your films. This may occur in an open area and may be overheard by others. A private review may be scheduled if you wish. Please let the medical assistant aware if you have any questions or concerns.

PAYMENT OF ACCOUNTS

INSURANCE CARD INFORMATION:
If you do not have your insurance cards available at the time of your appointment, you will be considered self-pay. Once we get a copy of your insurance card and your policy number in our system we can then bill your insurance for all visits.

NO INSURANCE:
If you do not have insurance, payment is expected at time of service. A minimum of $200.00, excluding any x-rays, injections, or procedures is expected at check in. We realize that injuries are unexpected and money is not always available. If the full amount cannot be paid at time of service, then prior arrangements must be made with the Patient Accounts Department.
We do not accept or file liability insurance. If you have a claim which you are filing with liability, we will be happy to give you a receipt showing your payment. You may file this for your re-imbursement.

INSURED PATIENTS:
Payment of deductibles and co-payments is expected at the time of service. Cash, Check, MasterCard and Visa are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company. Please be aware that depending on the procedure performed (x-rays, labs or injections), you may receive statements and insurance billing from Margaret R. Pardee Memorial Hospital and/or Southeastern Sports Medicine. Please note if you have a deductible with your insurance these procedures could be applied toward it.

I have read and accept the above medication, x-ray, and payment of accounts policies.

Patient Signature: ____ Date: _________________

Witness Signature: ____ Date: __________________

THANK YOU SOUTHEASTERN SPORTS MEDICINE