Southwest Orthopaedic Group

PATIENT REGISTRATION FORM

Name:(last)_____(first)_____(middle)_____
Social Security #:_____D.O.B:_____Sex:_____
Home Address Street:_____City:_____State:_____Zip:_____
Home Tel #:_____Work Tel #:_____Cell #:_____
Referring Physician:_____Tel #:_____
Employer Name:_____
Employer Address:_____
Patient Race :_____Patient Ethnicity :_____Preferred Language.:_____
Pharmacy Name:_____Pharmacy Phone #:_____
Pharmacy Address:_____
Patient Marital Status:_____Name of Spouse:_____D.O.B.:_____
Are you currently living in a skilled nursing facility/rehab unit?: YES / NO If yes, please provide the following:
Facility Name:_____Phone #:_____
Facility Address:_____

IN CASE OF EMERGENCY

Who may we call in case of emergency? Name:_____
Relationship to patient:_____Primary Tel #:_____Secondary Tel #:_____

BILLING INFORMATION

Name of person responsible for bill (Guarantor):_____
Address Street:_____City:_____State:_____Zip:_____
Home Tel #:_____Work Tel #:_____
Guarantor Social Security #:_____D.O.B.:_____
Name of employer of guarantor:_____
Address Street:_____City:_____State:_____Zip:_____

INSURANCE INFORMATION

Primary Insurance Carrier:_____
Address on back of card: Street:_____City:_____State:_____Zip:_____
Adjuster Name:_____Tel #:_____
Secondary Insurance Carrier:_____

Address on back of card: Street:_____City:_____State:_____Zip:_____
Is this visit due to (circle one): Personal Injury / Auto Accident / Work Related
Date of Injury:_____
Please list what you are being seen for today:_____

Patient Signature: X_____Date:_____

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PATIENT HISTORY / INJURY REPORT FORM

Account #: _____ Date: _____

Patient's Legal Name: _____

Sex: AGE: _____

Who is your primary care doctor? _____

Who referred you for this visit? ☐ Family Doctor ☐ Other Physician ☐ Friend

What problems are you being seen for today? _____

_____

How did this happen? _____

_____

_____

_____

_____

When did it happen? _____

Date of injury: _____

Is this a work-related problem?: ☐ Yes ☐ No

Was injury reported to your employer? ☐ Yes ☐ No

If you answered YES, have you filed a claim with
Worker's Compensation or are you planning on filing a claim with Worker's Compensation? ☐ Yes ☐ No

Contact person with your employer? _____

Are you presently working? ☐ Yes ☐ No If no, how long have you been off work? _____

Have you been seen anywhere else for this, or a similar problem? ☐ Yes ☐ No

If yes, please state When _____ Where _____

By whom _____

Were x-ray/MRI films taken? ☐ Yes ☐ No

If x-ray/MRI films were taken please state: When _____ Where _____

☐ **The above information does not apply to me. My injury is not work related.**

X _____
Signature of Patient/Representative

_____
Name of Patient/Representative

_____
Description of Personal Representative's Authority

Date:

PAST SURGICAL HISTORY: CHECK ALL ITEMS THAT APPLY TO YOU

☐ NONE

	Date of Surgery		Date of Surgery
☐ Thyroid surgery		☐ Gallbladder surgery	
☐ Hernia repair		☐ Breast surgery	
☐ Cardiac surgery		☐ Appendectomy	
☐ Tonsil/adenoidectomy		☐ Angioplasty	
☐ Wisdom teeth removal		☐ Organ transplant	
☐ Cesarean section			
☐ Other			

MEDICATIONS: GIVE NAMES, STRENGTH AND DOSAGE FOR ALL THAT APPLY

☐ NONE

Name	Strength	Dosage

ALLERGIES: LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION

☐ NONE

Name	Reaction

PAST MEDICAL HISTORY - CHECK ALL ITEMS THAT APPLY TO YOU

☐ Hypertension	☐ Diabetes	☐ Liver Disease	☐ Colitis
☐ Heart Disease	☐ Hypoglycemia	☐ Gallbladder Problems	☐ Prostate Disease
☐ Heart Attack	☐ Asthma	☐ Pancreatitis	☐ Gout
☐ Stent Placement	☐ COPD	☐ Thyroid Problems	☐ Jaundice
☐ Mitral Valve Prolapse	☐ Emphysema	☐ High Cholesterol	☐ Polio
☐ Stroke	☐ Bronchitis	☐ Seizures/Epilepsy	☐ Migraines
☐ Blood Clots	☐ Pneumonia	☐ Stomach Ulcers	☐ Other_____
☐ Anemia	☐ Kidney Disease	☐ Hiatal Hernia	
☐ Hepatitis	☐ Rheumatoid Arthritis	☐ Mental Illness	☐ Rotator cuff injury
☐ Cubital tunnel release	☐ Carpal tunnel release	☐ Sleep Apnea	☐ Pacemaker/Defibrillator

Cancer: ☐ Lung ☐ Breast ☐ Colon/Intestinal ☐ Stomach ☐ Prostate
☐ Skin ☐ Kidney ☐ Bone ☐ Other Malignancy

Have you been or are you now being seen by a cardiologist? ☐ Yes ☐ No

If yes, by whom?_____ When was your last visit?_____

Have you ever had an adverse reaction to anesthesia? ☐ Yes ☐ No

If yes, please describe?_____

ORTHOPAEDIC SCREEN: CHECK ANY CONDITIONS YOU HAVE NOW OR IN THE PAST

☐ Back Pain ☐ Ruptured Discs ☐ Sciatica ☐ Scoliosis ☐ Bursitis
☐ Fractures ☐ Frequent Sprains ☐ Dislocations ☐ Osteoporosis ☐ Bone Infections
☐ Tumors ☐ Tendinitis ☐ Gout ☐ Osteopenia
☐ Other

SOCIAL HISTORY

Please fill out any changes below:

Smoking Status: ☐ Never ☐ Former ☐Every day ☐ Some days ☐ Current status unknown ☐ Unknown if ever smoked

Smoking - How much?: ☐ None ☐ 1 PPW ☐2 PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1 PPD ☐ 2 PPD ☐ 3+PPD

Chewing tobacco: ☐ None ☐ 1 day ☐ 2-4 day ☐ 5+ day

Tobacco-years of use:_____

Do you drink alcohol?: ☐ Never or rare ☐ Social ☐ Frequent drunk ☐ Alcoholic ☐ Recovering alcoholic ☐ Moderate ☐ No

Drug Use?: ☐ Never ☐ Current ☐ In the past

Patients Marital Status: ☐ Unknown ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Number of children:_____ Please list their ages::_____

Please list your hobbies/interests:_____

Work Status: ☐ Full duty ☐ Light duty ☐ No duty ☐ Unemployed ☐ Retired

FAMILY HISTORY - PLEASE CHECK ANY OF THE PROBLEMS THAT IMMEDIATE FAMILY HAVE HAD, AND INDICATE THE FAMILY MEMBER

Please fill out any changes below:

	Family Member		Family Member
☐ Diabetes	_____	☐ High Blood Pressure	_____
☐ Heart Disease	_____	☐ Low Blood Pressure	_____
☐ Vascular Disease	_____	☐ Cancer	_____
☐ Bleeding Disorders	_____	☐ Other	_____
☐ High Cholesterol	_____		_____

WOMEN ONLY: PLEASE CHECK ALL ITEMS THAT APPLY TO YOU

☐ Endometrosis Are you pregnant? ☐ Yes ☐ No If yes, due date?_____

Patient Signature:_____ Date:_____

Reviewed By:_____ Date:_____

Physician Notes:_____

REVIEW OF SYSTEMS (GENERAL) CHECK ALL ITEMS THAT APPLY TO YOU

Constitutional Symptoms:	☐ Cough	☐ Fever	☐ Chills	☐ Sweats
	☐ Weight gain (lbs____)	☐ Weight loss (lbs____)	☐ Exercise Intolerance	
Skin:	☐ Abnormal mole	☐ Jaundice	☐ Eczema	☐ Rash
Head, Ears, Eyes, Nose, Throat:	☐ Dry eyes	☐ Eye irritation	☐ Vision changes	☐ Bleeding gums
Gastrointestinal:	☐ Blurred vision	☐ Sore throat	☐ Sneezing	☐ Frequent nose bleeds
	☐ Nose/sinus problems	☐ Dizziness	☐ Difficulty hearing	☐ Abdominal Pain
	☐ Frequent/severe headaches			
Respiratory:	☐ Wheezing	☐ Short of breath	☐ Cough up blood	
Cardiovascular:	☐ Chest pain upon exertion	☐ Arm Pain upon exertion	☐ Palpitations	☐ Shortness of breath with walking or lying down
	☐ No known heart murmur			
Neck:	☐ Swollen glands	☐ Neck stiffness		
Gastrointestinal:	☐ Abdominal pain	☐ Frequent urinations	☐ Vomiting	☐ Change of appetite
	☐ Black or tarry stools			
Genitourinary:	☐ Urinary loss of control	☐ Changes in urinary habits	☐ Urinary frequency	☐ Hematuria
	☐ Incomplete emptying	☐ Frequency	☐ Trouble urinating	
Musculoskeletal:	☐ Muscle aches	☐ Muscle weakness	☐ Arthralgia/Joint pain	☐ Back pain
Neurologic:	☐ LOC	☐ Weakness		
Psychological:	☐ Depression	☐ Mania	☐ Sleep disturbances	☐ Feeling unsafe in relationships
	☐ Alcoholism			

ADDITIONAL PATIENT INFORMATION - PLEASE PROVIDE ADDITIONAL EXPLANATION OF ANY RESPONSES ON THE BACK OF THIS SHEET

I herby certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

_____ Date: _____

Patient Signature

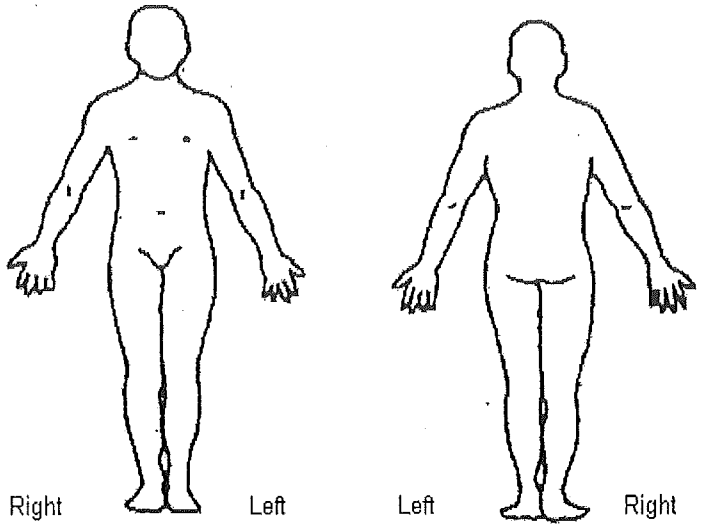
_____

Verified by Physician/Nurse

PAIN DRAWINGS

- Mark the area on your body where you feel the described sensations. Use the appropriate symbol(s). Use all symbols that apply.
- Mark the areas were the sensations travel, if any.
- Please include all affected areas.

Ache	Numbness	Pins and Needles	Burning	Stabbing
AAAA	OOOO	|||||||	****	VVVV



USING THE FOLLOWING SCALE, MARK THE BOX CORRESPONDING TO THE SEVERITY OF YOUR PAIN IN GENERAL: (0=NO PAIN, 10=PAIN IS AS BAD AS IT CAN BE)

0	1	2	3	4	5	6	7	8	9	10
No pain	Slight		Mild		Medium		Severe		Excruciating	Pain is as bad as it can be

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

☐ Copy given to patient
☐ Patient declined copy

Email Use

This practice may send email notification to you regarding appointment reminders or general health information you may be interested in. By giving us your email address, you have consented to receiving information from us.

Email address: _____

Consent to Obtain Medication History

Our practice is moving toward an electronic medical records environment. We have enabled new functionality where we are able to obtain your medication history from a pharmacy clearinghouse called Surescripts. Surescripts will provide your provider a 2 year medication history if you give consent for us to obtain this information. Please check the box below indicating your consent.

☐ I give consent to *SWOG* to obtain my 2 year medication history from Surescripts
☐ I **do not** wish to allow *SWOG* to obtain my 2 year medication history from Surescripts

X _____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Date:

Southwest Orthopaedic Group

CANCELLATION POLICY

Any cancellations requested the day of the appointment **OR** less than 24 hours prior to your appointment is subject to cancellation fees.

- $40.00 Any Medical Examinations/Any Office Procedures
- $60.00 Scheduled Surgeries

Also, patients who arrive late by 15 minutes or more may be rescheduled to the next available appointment. If there is no other appointment available that day, every effort will be made to accommodate the patient; however, there is no guarantee that the patient will be seen. If you are running late please call us so we can facilitate the reorganization of appointments and improve your opportunity for being seen.

We strictly adhere to this policy. Please print and sign below to indicate that you have read and understand the above policy.

Print Patient/Legal Representative Name Date

Signature of Patient/Legal Representative Date

Witness Date

Southwest Orthopaedic Group

Financial Policy

Thank you for choosing Southwest Orthopaedic Group for your health care needs. We are committed to providing you with quality health care. The purpose of this financial policy is to advise you of your responsibility for services rendered. If you have any questions regarding this policy please let us know before signing.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at time of visit. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This agreement is part of your contract with your insurance company.
3. **Non-covered services.** Please be aware that some or all services you may receive may be non-covered services or not considered reasonable or necessary by insurer. You are responsible for payment of these services in full at time of visit.
4. **Proof of identification and insurance.** All patients must complete our patient information form prior to seeing the physician. We must obtain a copy an identification card (i.e. driver's license) and current valid proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission.** We will submit your claim and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. You are responsible for any remaining balances after your insurance processes your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you change coverage it is your responsibility to inform us of coverage changes.
7. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collections agency and you and your immediate family members may be discharged from this practice. If this is to occur, you may be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period our physicians will only be able to treat you on an emergency basis only.
8. **Overpayments and Underpayments.** Overpayments received from you will be applied to any outstanding balances on your account.
9. **Missed appointments.** Our policy is to charge for missed appointment not canceled within a reasonable amount of time (at least within 24 hours). These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
10. **Returned Checks.** Our office charges a $25 fee for returned checks.
11. **Billing Information.** If you have any questions regarding your account please contact our billing department at 512-451-5221. Please note our billing services are in Arizona and you may receive correspondence from PO Box 52194 Phoenix, AZ 85072 on our behalf.

I have read and understand the payment policy and agree to abide by its guidelines. In additional, I hereby give Southwest Orthopaedic Group the authority to check my credit when making payment arrangements with Southwest Orthopaedic Group and/or its contracted credit agency.

Patient Name_____ Acct#_____

Signature_____ Date: _____

CONTROLLED SUBSTANCE CONTRACT

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____ I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced regardless of the circumstances.

_____ Refills of controlled substance medications;

_____a) Will be made only during regular office hours *Monday through Friday, in person, once a month, and during a scheduled office visit.* Refills will not be made at night , weekends, or during holidays.

_____b)Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____c)I understand that I must call ahead within 72 hours to schedule an appointment.

_____ It may be deemed necessary by my doctor that I see a medication-use specialist (pain management) at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled.

_____ I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____ I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physican.

_____ I understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

_____ I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

I have been fully informed by _____ regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____