ATLANTIC ORTHOPAEDIC SPECIALISTS

Leaders in Orthopaedic Health

PATIENT REGISTRATION

Chart # _____ Today's Date _____ Physician's # _____

Patient's Name _____ Sex (check one) Male Female

Last *First* *Initial*

(NAME AS IT APPEARS ON INSURANCE CARD)

Race _____

Ethnicity _____

Birth Date _____ Age _____ Patient's Social Security # _____ If none, Parent's S.S. # _____

Guarantor's Name _____

Patient's Address: Street _____ Apt. / Suite #_____

City _____ State _____ Zip _____

Skilled Nursing Facility _____ Patient Email: _____

Guarantor's Address: Street_____

If different from patient) City _____ State_____ Zip_____

Home Phone #: _____ Mobile Phone #: _____ Work Phone #: _____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** *(if different)*_____

(First, Last Name) (First, Last Name)

INSURANCE

If an injury, date of injury _____ Date of first symptoms _____ Date any physician first consulted _____

(Check one) ☐ Work Related ☐ Auto Accident ☐ Other _____

	PRIMARY	SECONDARY	AUTO INSURANCE
Insurance Company			Insurance Name:
Subscriber's Name			
Subscriber's Sex	[ ] M [ ] F	[ ] M [ ] F	Insurance Address:
Subscriber's Birth Date			
Subscriber's SSN			
Relationship to Patient			Name of Insured:
Policy Effective Date	From_____To_____	From_____To_____	
Policy #			Policy #:
Group #			

Marital Status (check one) Married Single Divorced Widow (er) Separated

Have you been seen by any orthopaedic physician? YES NO If yes, who _____ when _____

How did you hear about our practice? Referring Doctor Friend Family Hospital ER Patient Employer Attorney Trainers TV/Radio Yellow Pages Internet Advertisement Other (Please specify) _____

Patient's Complaint (describe accident or problem)_____

If you are being treated for an accident/injury and you have an attorney, please give the name of your attorney _____

Treated at a Hospital? YES NO Name of Hospital _____

Were x-rays taken? (check one) YES NO Where are they located? _____

Patient or Guarantor's Employer Name _____ Occupation _____

Address _____

Spouse's Name and Employer _____ Work Telephone _____

Closest Relative / Friend (Not in Home) Preferred language English Spanish Other _____

Name _____ Telephone _____

Address _____

PLEASE READ INFORMATION ON THE REVERSE SIDE OF THIS PAGE AND SIGN

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN

I HEREBY CONSENT TO TREATMENT by Atlantic Orthopaedic Specialists physicians, their associates, and/or assistant and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances, and/or such other procedures as deemed necessary.

I understand that payment (or co-payment) is expected at the time of service, and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not paid by this authorization. I further understand if a balance results on my account at the time of any litigation settlement relating to injuries for which I am being seen, my account with this practice will be the first bill paid in full at the time of settlement. I assign benefits from claims made by or on behalf of me for any insurance coverage, workers' compensation, governmental agency or disability benefits, and I assign proceeds from all settlements, judgements or verdicts in my favor from third-party liability claims for injuries treated hereunder, in a amount equal to the full amount of all charges (including attorney's fees, collection action fees, costs and interest) due hereunder, is made to Atlantic Orthopaedic Specialists (AOS) without offset. I acknowledge and agree that such assignments shall not be revoked. I grant Atlantic Orthopaedic Specialists (AOS) a lien in like amount and they are authorized to receive direct payment of all assigned benefits / proceeds. Any attorney, insurance carrier or agency handling or disbursing such benefits or proceeds is ordered, authorized and directed to withhold and promptly pay over to Atlantic Orthopaedic Specialists (AOS) the lesser of the full amount of their charges or the total net proceeds or benefits available without offset. Should any Atlantic Orthopaedic Specialists physician qualify and testify as an expert witness on my behalf, in any legal or administrative proceeding or deposition, including appearances cancelled within 7 days, I understand that I will be liable for such physician's fee as an expert witness. Should collection actions become necessary, I understand that I will be liable for all costs associated with collecting the unpaid balance owing on my account, including reasonable attorney fees of 33 1/3% of the unpaid balance owing on my account.

I hereby authorize the release of any information necessary for filing of any insurance and direct payment to the Atlantic Orthopaedic Specialists physicians for any amounts due under my present policy(ies) or any policy that I may at a later date ask to be filed. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise Atlantic Orthopaedic Specialists of any changes in insurance coverage.

I also authorize Atlantic Orthopaedic Specialists to talk with and exchange information with other medical professionals regarding my medical condition. The medical professionals include, but are not limited to: physical therapists, occupational therapists, athletic trainers, nurses, physicians assistants, rehabilitation specialists, case workers, primary care physicians, referring physicians, nurse practitioners and diagnostic CT scans (interpreted by MRI&CT).
If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I *agree* to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

I also authorize Atlantic Orthopaedic Specialists to verbally disclose my personal medical information to: _____ _____for the purpose of my ongoing medical care. I understand that Atlantic Orthopaedic Specialists may not condition treatment or payment on my willingness to sign this authorization unless specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I understand that I may revoke this authorization at any time by notifying Atlantic Orthopaedic Specialists in writing.

However, if I choose to do so, I understand that my revocation will not effect any actions taken by Atlantic Orthopaedic Specialists before receiving my revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected. I understand that this authorization will expire upon the termination of my status as a patient of Atlantic Orthopaedic Specialists.

Signed: _____ _____ _____
Patient, Parent or Guardian | Date | Witness

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Atlantic Orthopaedic Specialists for any services furnished me by Atlantic Orthopaedic Specialists. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ _____ _____
Patient, Parent or Guardian | Date | Witness

Atlantic Orthopaedic Specialists files your insurance as a courtesy to you. If a co-payment or co-insurance is due from you, your insurance company, HMO, or managed care company requires us to collect this payment at the time of service. We accept cash, check, Mastercard, and VISA.

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PATIENT MEDICAL HISTORY

Date _____

Chart # _____

PC _____

Patient's Name _____ Ref. Physician: _____

Date of Birth _____ Age _____ Weight _____ Height _____ Blood Pressure if known _____

Problems with Anesthesia? ☐ YES ☐ NO If yes, explain _____

Current Complaints _____ Date of Last Tetanus _____

Allergies / Difficulties with Medication & Reaction ☐ None ☐ Latex ☐ Metal /Jewelry	Current Medication	How Taken ☐ None

Are you: ☐ Right handed ☐ Left handed

PERSONAL INFORMATION

☐ No Illnesses	☐ Common Cold	☐ Intestinal Problems	☐ Sleep Apnea
☐ AIDS / HIV	☐ Diabetes	☐ Mental / Nervous Disorder	☐ Stroke
☐ Angina	☐ DVT / Blood Clot	(Specify) _____	☐ Tendonitis
☐ Asthma	☐ Emphysema	☐ Pancreatitis	☐ Tuberculosis
☐ Arthritis	☐ Gallbladder Disease	☐ Pneumonia	☐ Ulcers
☐ Bladder / Kidney Infection	☐ Heart Attack	☐ Psoriasis	☐ Varicose Veins
☐ Bleeding Disorders	☐ Heart Disease	☐ Raynaud's Disease	☐ Venereal Disease
☐ Bronchitis	☐ Heart Murmur / Valve Problem	☐ Scarlet Fever	☐ Other:
☐ Bursitis	☐ Hepatitis	☐ Seizures	☐ _____
☐ Cancer	☐ High Blood Pressure	☐ Sinusitis	☐ _____

SOCIAL HISTORY

Do you smoke tobacco products? ☐ Yes, _____ pack(s) per day ☐ NO (Please choose one of the following below)
☐ I would like to quit ☐ Never smoked ☐ Former smoker

Do you drink alcohol? ☐YES ☐NO Do you have a history of alcohol addiction? ☐YES ☐NO Number of drinks per day? _____ per week? ____

Do you take drugs? ☐YES ☐NO Do you have a history of chronic drug use? ☐YES ☐NO Do you have a history of drug addiction? ☐YES ☐NO

Check all that apply: ☐Marijuana ☐Cocaine ☐Others (Specify) _____ Are you in pain management? ☐YES ☐NO

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Number of Children _____

Employment: (Type) _____

FAMILY HISTORY (Siblings, parents and children)

☐ No Diseases	☐ High Blood Pressure	☐ Other (specify)
☐ Asthma	☐ Kidney Disease	_____
☐ Arthritis	☐ Problems with Anesthesia	
☐ Cancer	☐ Seizures	_____
☐ Diabetes	☐ Stroke	
☐ Excessive Bleeding	☐ Tuberculosis	_____
☐ Heart Disease		

PHARMACY

Name _____

Location _____

Alternate Name _____

Location _____

Physician's Signature _____ Therapist's Signature _____

Previous Surgery: ☐ None Dates

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months): ☐ None

☐ Chest X-ray ☐ Stress Test ☐ Blood Work ☐ EKG

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)

General: ☐ None
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Change

Gastrointestinal: ☐ None
☐ Nausea
☐ Vomiting
☐ Pain / Difficulty Swallowing
☐ Gas
☐ Indigestion
☐ Abdominal Pain
☐ Bloating
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids
☐ Bloody Stools

Musculoskeletal: ☐ None
☐ Fracture
☐ Sprain
☐ Strains
☐ Dislocations
☐ Joint Stiffness
☐ Joint Pain
☐ Joint Swelling
☐ Back Pain

Head: ☐ None
☐ Headaches
☐ Blackouts
☐ Seizures
☐ Dizziness

Heent: ☐ None
☐ Hearing Loss
☐ Double Vision
☐ Blurred Vision
☐ Ringing in Ears
☐ Post Nasal Drip
☐ Sore Throat
☐ Hoarseness

Genitourinary: ☐ None
☐ Blood in Urine
☐ Burning with Urination
☐ Bladder / Kidney Infections
☐ Frequency Urination
☐ Difficulty Starting Urination
☐ Sense of Full Bladder
☐ Urine Leaking
☐ Getting Up / Urinating at Night

Skin: ☐ None
☐ Rash
☐ Itching
☐ Change / Bleeding Mole

Respiratory: ☐ None
☐ Cough
☐ Sputum
☐ Coughing up Blood
☐ Wheezing

Cardiovascular: ☐ None
☐ Shortness of Breath
☐ Chest Pain
☐ Palpitation
☐ Heart Murmur
☐ Swelling of Feet
☐ Night Cramps

FEMALE PATIENTS

Do you take Birth Control Pills? ☐ YES ☐ NO If yes, type? _____

Do you take PREMARIN or ESTROGEN or other hormonal replacement? ☐ YES ☐ NO If yes, type? _____

Is there any chance you are pregnant? ☐ YES ☐ NO

I certify that above information is accurate and complete to the best of my knowledge. I will not hold Vann-Virginia Center for Orthopaedics, P.C., its physicians or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____