



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)

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

Guarantor's Name _____ Race _____ Ethnicity _____

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 _____

Primary Phone #: _____ Secondary 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) <input type="checkbox"/> Work Related <input type="checkbox"/> Auto Accident <input type="checkbox"/> 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 _____

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.

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

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

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 Number of drinks per day? _____ per week? _____

Do you take drugs? YES NO Check all that apply: Marijuana Cocaine Others (Specify) _____

Marital Status: Married Single Divorced Separated Number of Children _____

Employment: (Type) _____

FAMILY HISTORY (Siblings, parents and children)

<input type="checkbox"/> No Diseases	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Problems with Anesthesia	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> 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

Head: None

- Headaches
- Blackouts
- Seizures
- Dizziness

Skin: None

- Rash
- Itching
- Change / Bleeding Mole

Gastrointestinal: None

- Nausea
- Vomiting
- Pain / Difficulty Swallowing
- Gas
- Indigestion
- Abdominal Pain
- Bloating
- Constipation
- Diarrhea
- Hemorrhoids
- Bloody Stools

Heent: None

- Hearing Loss
- Double Vision
- Blurred Vision
- Ringing in Ears
- Post Nasal Drip
- Sore Throat
- Hoarseness

Respiratory: None

- Cough
- Sputum
- Coughing up Blood
- Wheezing

Musculoskeletal: None

- Fracture
- Sprain
- Strains
- Dislocations
- Joint Stiffness
- Joint Pain
- Joint Swelling
- Back Pain

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

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 _____