Name: _____
DOB: _____
Chart: _____
Age/Gender: _____
Date: _____

Patient Registration Form

Please fill out completely

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

SS# _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race(please choose one): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined

Ethnicity(please choose one): ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Declined

Preferred Language: _____

Are you employed? ☐ Yes ☐ No ☐ Disabled ☐ Retired ☐ Other: _____

Employer: _____ Employer Phone: _____

Are you a student? ☐ Yes ☐ No Name of School: _____

Spouse's Name: _____ SS#: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____ Relation to Patient: _____

Preferred Pharmacy Information: Please fill out as much information as possible.

Pharmacy Name: _____ Pharmacy Phone Number: _____

Intersection or address if known: _____ City: _____ Zip Code: _____

If the patient is a minor under age 18, please list the responsible party.

Last Name: _____ First Name: _____ Relation to Patient: _____

Sex: ☐ Male ☐ Female SS#: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Are you employed? ☐ Yes ☐ No ☐ Disabled ☐ Retired ☐ Other: _____

Employer: _____ Employer Phone: _____

Medical Insurance Information

Primary Insurance Company: _____ Phone: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Subscriber ID / Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ Policy Holders DOB: _____

Policy Holders SS #: _____ Insured Employer: _____

Secondary Insurance Company: _____ Phone: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Subscriber ID / Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ Policy Holders DOB: _____

Policy Holders SS #: _____ Insured Employer: _____

Please Continue on the Next Page →

Name: _____
DOB: _____
Chart: _____
Age/Gender: _____
Date: _____

SUBURBAN ORTHOPAEDICS

If you have any questions, or are not sure how to answer any of these questions, please do not hesitate to ask for help.

Is this visit related to an accident or injury?	☐ Yes	☐ No
Is this visit related to an accident, injury or otherwise, related to your workplace?	☐ Yes	☐ No
Is this visit related to an accident or injury at a school event?	☐ Yes	☐ No
Is this visit related to an auto accident or injury?	☐ Yes	☐ No
Is this visit related to an accident or injury other than auto, employment, or school event?	☐ Yes	☐ No

If yes, please describe: _____

For Workers' Compensation Claims - Please complete the following:

Employer at time of injury: _____ Date of injury: _____
Address: _____ City: _____ State: _____ Zip: _____
Have you filed a claim with your employer: ☐ Yes ☐ No Employer Contact Person: _____
Name of Workers' Comp Insurance Co: _____ CLAIM #: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Insurance Contact Person: _____ Phone: _____ Fax: _____

For Auto, or "Other" Insurance Claims - Please complete the following:

Date of Accident or Injury: _____ CLAIM #: _____
Auto or "Other" Insurance Company: _____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Phone: _____

Legal Information

Attorney Name: _____ Phone: _____
Address: _____ Fax: _____

How did you hear about us?

☐ Physician (please complete below)
Name: _____
Phone: _____
Do you have a Primary Care Physician (PCP)? ☐ Yes ☐ No
Primary Care Physician: _____ Phone: _____

☐ Family Member
☐ Friend
☐ Internet/Website
☐ High School

☐ Yellow Pages
☐ Advertisement
☐ Patient
☐ Location

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to (Suburban Orthopaedics) Consultants. I authorize (Suburban Orthopaedics) Consultants to release any information, acquired in the course of my treatment, needed for my medical insurance claim(s). A photocopy of this authorization is to be considered valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I understand that I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. I understand that copays are expected at the time services are rendered. I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Name: _____
DOB: _____
Chart: _____
Age/Gender: _____
Date: _____

SUBURBAN ORTHOPAEDICS

Please fill out completely

Patient Medical History

How where you referred to us? _____ **Who is your primary care physician?** _____

Hand Dominance: ☐ Right ☐ Left **Occupation:** _____ **Height:** ft in **Weight:** lbs

Do you have any hobbies or play sports? _____

Body Part Affected: What Hurts? ☐ Right ☐ Left

When did this start? _____ **What do you feel?** ☐ Pain ☐ Numbness ☐ Weakness ☐ Stiffness
☐ Popping/Grinding ☐ Swelling ☐ Unstable ☐ Other

Where did the injury/symptoms occur? ☐ at home ☐ at work ☐ during sports/recreational ☐ car accident ☐ at school ☐ other _____

How did the Injury/symptoms occur? ☐ sudden/traumatic ☐ lifting/bending ☐ gradual onset ☐ injury relating to a fall ☐ recurrence of previous injury ☐ other

Allergies: ☐ No known allergies

		Reaction			Reaction
Latex	☐		Eggs	☐	
Penicillin	☐		Shellfish	☐	
Sulfa	☐		Radiological Dyes	☐	
Iodione	☐				
Soy	☐		Other		

Review of Systems: **Do you currently have the following?**
(Check all that apply)

Fevers	☐ No	☐ Yes		**Stomach pain**	☐ No	☐ Yes
Vision changes	☐ No	☐ Yes		**Urination problems**	☐ No	☐ Yes
Hearing changes	☐ No	☐ Yes		**Mole changes**	☐ No	☐ Yes
Chest Pain	☐ No	☐ Yes		**Weight loss/gain**	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes		**Easy bleeding**	☐ No	☐ Yes
				Pregnant	☐ No	☐ Yes

Medical History:
☐ None
☐ Heart Disease
☐ Stroke/TIA
☐ Hypertension
☐ Diabetes
☐ Arthritis
☐ Other _____

Surgical History: ☐ NONE

Procedure	Year Done

Current Medications: ☐ None ☐ See Attached
Please list all meds. Continue on reverse if needed

Medication	Dose Strength

Family History: _____ ☐ Unknown ☐ Adopted

			Disease/Illness
Mother	☐ None	☐ Deceased	
Father	☐ None	☐ Deceased	
Brother(s)	☐ None	☐ Deceased	
Sister(s)	☐ None	☐ Deceased	
Maternal Grandparents	☐ None	☐ Deceased	
Paternal Grandparents	☐ None	☐ Deceased	
Other			

Did you have complications from anesthesia? ☐ No ☐ Yes (If yes, please explain)

Social History:
Did you smoke? ☐ No ☐ Yes Quit date_____ How long did you smoke?_____ yrs Amount_____ packs/day
Do you smoke? ☐ No ☐ Yes ☐ Cigarettes _____ packs/day ☐ Cigars _____ per day ☐ Pipe _____ per day
Do you chew tobacco? ☐ No ☐ Yes
Do you use recreational drugs? ☐ No ☐ Yes Type_____ Quit Date_____
Do you drink alcoholic beverages? ☐ No ☐ Yes Abuse? ☐ No ☐ Yes Quit Date_____
If yes, how often? ☐ Socially ☐ Rarely ☐ Daily drinks/day ☐ Weekly

Name: _____
DOB: _____
Chart: _____
Age/Gender: _____
Date: _____

Acknowledgement of Suburban Orthopaedics Policies

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I acknowledge that I received, reviewed or was offered the HIPAA of Privacy Practices of Suburban Orthopaedics.

Initials: _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I verify that I have received, reviewed or was offered a copy of Suburban Orthopaedics financial policy.

Initials: _____

DEMOGRAPHICS & MEDICAL HISTORY INFORMATION

I have reviewed the demographic and medical history information. I verify that all the information is current and accurate to my knowledge.

Initials: _____

ACKNOWLEDGEMENT OF RX POLICY

I verify that I have received, reviewed or was offered a copy of Suburban Orthopaedics Rx Policy.

Initials: _____

EMERGENCY CONTACT NAME:

Name: _____ Phone Number: _____

INFORMATION RELEASE

I authorize my private health information to be discussed with the following people, either over the phone or in the office.

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

I authorize private health information to be left on a voicemail/answering machine at the following numbers:

Phone Number	**Location (home/work/cell)**
_____	_____
_____	_____
_____	_____

I verify that I have read all of the above.

Signature: _____ **Date:** _____

Medication Contract

I understand that the medical treatment I receive may include opioid medicine, also known as narcotics, pain medicine, analgesics, and/or sedative medications. I understand and agree with the following:

1. Opioid and/or sedative therapy will not cure my underlying disease or condition.
2. The goals of these medications are to increase my activities at home and/or work and decrease my pain symptoms and behavior within the time specified in my treatment plan.
3. Chronic pain represents a complex problem that may benefit from physical therapy, surgery and behavioral medicine treatments. My active participation in the management of my pain is extremely important. I will actively participate in all pain management treatments prescribed by the providers at Suburban Orthopaedics.
4. Opioid, and/or sedative medications may be addictive, and abuse of these drugs may have harmful effects on my health. Common side effects that are related to opioid medication are: nausea and vomiting, drowsiness, itching, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, constipation and the possibility that the medicine will not provide complete pain relief. It is my responsibility to notify my medical provider for any side effects that continue or are severe (i.e. sedation or confusion).
5. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might be slowed. Such activities include but are not limited to: operating heavy equipment or a motor vehicle, working while operating machinery or around dangerous equipment, or being responsible for another individual who is unable to care for him/herself.
6. I will not obtain an opioid or sedation medications from any source other than the providers at Suburban Orthopaedics. If I require emergency treatment that requires opioid or sedative medications I will notify my provider Suburban Orthopaedics the next business day.
7. I will receive all medications from one pharmacy. If I change pharmacies I will immediately notify the providers and staff at Suburban Orthopaedics of that change. I will furnish the providers and staff at Suburban Orthopaedics with the name and phone number of this pharmacy for the purpose of random verification of prescriptions.
8. I authorize the providers and staff of Suburban Orthopaedics to communicate with and provide this contract to my pharmacy and my other physicians.
9. Lost or stolen medications and/or prescriptions may or may not be replaced. It is my responsibility to report lost or stolen medications to the police.
10. I understand the opioid medication is strictly for my own use. The medication should never be given to others.
11. All medications are to be taken strictly as prescribed for dosage and frequency. I understand that increasing my dose without close supervision of my physician could lead to drug overdose causing sever sedation, respiratory depression and death. Decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms my include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, goose bumps, abdominal cramps and diarrhea. These symptoms can occur after the last dose and can last up to 3 weeks.

Medication Contract

12. I will not use any illegal substances, including but not limited to marijuana, cocaine, etc.
13. I will notify my medical provider before taking Benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Soma, Xanax, Fiorinal) and antihistamines (drugs like Benadryl). I understand the combined use of the above drugs and opioid may produce profound sedation, respiratory depression, blood pressure drop, and death.
14. Urine or blood drug screens may be performed by the providers at Suburban Orthopaedics to monitor drug usage.
15. Refill request must allow 3 business/working days to fill the request. No requests will be filled on evenings, Fridays, Saturdays, Sundays or Holidays, UNDER ANY CIRCUMSTANCES.
16. Any specific medication warning must be followed, i.e. drowsiness.
17. Office visits as scheduled by the providers at Suburban Orthopaedics must be kept in order to continue receiving refills on your prescribed pain medication.

I understand that if I have a problem or question regarding any of the information provided in this agreement I must make an appointment to discuss this with a medical provider at Suburban Orthopaedics to clarify information BEFORE A PROBLEM OR CRISIS SITUATION ARISES.

In particular, if I have had a history of drug or alcohol abuse I must discuss this with a medical provider at Suburban Orthopaedics before being prescribed medication by said provider.

I understand that the providers at Suburban Orthopaedics will cancel my contract if I fail any part of the above agreement. Upon cancellation of my contract the providers at Suburban Orthopaedics will wither stop or taper me off my medications as necessary. A drug-dependence treatment program may be recommended.

I have read and understand this contract. A copy of this signed contract has been given to me for reference. All of my questions have been answered in a satisfactory manner. I understand my compliance with this contract is mandatory to continuing my medication treatment with the providers at Suburban Orthopaedics. I consent to the use of medication in the treatment of my pain as outlined in this contract.

_____ _____

Patient's Signature Date

_____ _____

Physician's Signature Date

_____ _____

Witness's Signature Date