Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last)_____(First)_____(MI) _____ Previous Name _____

Address Line 1 _____

City, State_____ZIP _____

Home Phone_____Cell No._____Work Phone_____Ext._____

Primary Care Provider (PCP)_____Referring Provider _____

Rendering Provider Name (this practice)_____E-Mail Address:_____

Date of Birth MM_____/DD_____/YYYY_____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name_____ First Name _____

Phone Number_____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient_____☐ Guardian

Address Line 1 _____

City, State_____ ZIP _____

Home Phone_____Work Phone_____Ext._____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last)_____(First)_____ (MI)_____

Guarantor Account Number_____Date of Birth MM_____/DD_____/YYYY_____

Social Security Number_____-_____-_____Telephone _____

E -Mail Address_____Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State_____ZIP _____

Employer_____ Employer Phone Number_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____(_____)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____Copay Amount_____ Effective Date_____Termination Date_____Date of Birth MM_____/DD_____/YYYY_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____(_____)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____Copay Amount_____

Effective Date_____Termination Date_____Date of Birth MM_____/DD_____/YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

St. David's | Center for Hip and Knee Replacement

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

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PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

PATIENT NAME_____**DATE OF BIRTH**_____

1. _____**(Patient or Guardian Initials)**

Financial Agreement. (A photocopy of this consent shall be considered as valid as the original).

- I acknowledge, that as a courtesy, **ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT** any insurance or other third-party benefits available for health care services provided to me. I understand **ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT** by the Medicare or Medicaid program.

5. _____**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that
ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or
ST. DAVID'S CENTER FOR HIP AND KNEE REPLACEMENT or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____**(Patient or Guardian Initials)**

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient. (Circle from the list below):

☐Spouse ☐Parent ☐Guarantor ☐Healthcare Power of Attorney ☐Legal Guardian ☐Other: ☐

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MEDICAL HEALTH HISTORY

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last name:	First:	MI:

Work Injury?	Date of Injury?	Height:	Birth date:	Sex:
☐ Yes ☐ No		Weight:		☐ M ☐ F

CHIEF COMPLAINT

Where is your pain? ☐ Hip ☐ Right ☐ Left ☐ Both

☐ Knee ☐ Right ☐ Left ☐ Both

Describe the injury/accident or how did the pain start: _____

_____

_____

Date when your pain begun: _____

Describe the type of pain you're having: ☐ Burning ☐ Aching ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Shooting ☐ Numbness/Tingling

What makes the pain worse? (Ex: Walking, Running, Sitting, etc.)_____

_____

What makes the pain better? (Ex: Rest, Ice, etc.) _____

_____

What is the severity of your pain (please circle one): (Least) 1 2 3 4 5 6 7 8 9 10 (Worst)

What medications are you currently taking to manage your pain?(i.e. Aleve, Tylenol, Advil)

_____

_____

Have you had Physical Therapy for this problem? ☐ Yes ☐No If yes, what facility did you go to? _____

_____

Have you had any imaging/testing for this problem in the last 3 months? ☐Yes ☐No If yes, what facility did you go to?

_____

_____

Have you had surgery in the location of your pain? ☐Yes ☐No If so, what type of surgery and where:_____

_____

Have you had injections for this problem? (ie: Cortisone/Viscosupplementation-Synvisc, Orthovisc, Euflexxa) ☐Yes ☐No

If so, what kind? When was your last injection? _____

NOTES (FOR OFFICE USE ONLY)

*Vital Signs- * *	
*History of Falls- * *	
*Flu- *	
*Pneumonia-	

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MEDICATIONS

Do you have any kind of Metal Allergy? ☐ Yes ☐ No If yes, then what type/kind of metal? _____

Any medication allergies? ☐ Yes ☐ No ☐ Sulfa ☐ Penicillin ☐ Latex ☐ Tape ☐ Shellfish ☐ NSAID's

If other, please list medication(s) and reaction(s): _____

_____

_____

Do you currently see a pain management doctor? ☐ Yes ☐ No If yes, then who? _____ Phone: _____

Please list all medications including Prescription, OTC, and Vitamins with dosages:

_____mg/IU	_____mg/IU	_____mg/IU
_____mg/IU	_____mg/IU	_____mg/IU
_____mg/IU	_____mg/IU	_____mg/IU
_____mg/IU	_____mg/IU	_____mg/IU
_____mg/IU	_____mg/IU	_____mg/IU

Preferred Pharmacy and phone number: _____

Have you had an Influenza Vaccine? ☐ Yes ☐ No If yes, then when? _____ Where (PCP office, Pharmacy)? _____

Have you had the COVID-19 Vaccine? ☐ Yes ☐ No If yes, then when? _____ Where (PCP office, Pharmacy)? _____

Have you had a Pneumonia Vaccine? ☐ Yes ☐ No If yes, then when? _____ Where (PCP office, Pharmacy)? _____

Have you fallen in the last 12 months? ☐ Yes ☐ No If yes, then when? _____ How many times? _____

Have you fallen in the last 3 months? ☐ Yes ☐ No If yes, then when? _____ How many times? _____

MEDICAL HISTORY

General

☐ Diabetes ☐ Seizure Disorder ☐ HIV/AIDS ☐ History of Polio ☐ Depression/Anxiety ☐ Thyroid Disease ☐ Gout

Blood

☐ Anemia ☐ Cancer ☐ History of Blood Clots

Cardiovascular

☐ Hypertension ☐ CAD (Coronary Artery Disease) ☐ Pacemaker/Defibrillator ☐ History of Stroke ☐ High Cholesterol

GI/GU

☐ Bowel Disorder ☐ History of GI Bleed ☐ Hepatitis ☐ Kidney Problems ☐ Liver Problems ☐ Reflux Disease ☐ History of Ulcers

Ortho

☐ RA (Rheumatoid Arthritis) ☐ Osteoarthritis ☐ Spine/Back Problems ☐ History of: Fractures/Sprain/Strain/Tear – Date of Injury: _____

Respiratory

☐ Asthma ☐ Lung Disease ☐ Tuberculosis ☐ Other: _____

Auto Immune Deficiency

☐ Multiple Sclerosis (MS) ☐Guillain-Barre (GB) ☐Psoriasis ☐Graves' ☐Hashimoto's ☐Inflammatory Bowel Disease (IBD) ☐ Lupus

☐Other: _____

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Infections

☐ MRSA ☐ MSSA ☐ VRE ☐ C-DIFF

If yes to any, please list dates: _____

SURGICAL HISTORY

List any past surgeries including Orthopedic related surgeries: _____

_____

_____

_____

FAMILY HISTORY

Do you have children? ☐ Yes ☐ No If yes, then how many?_____Do you have siblings? ☐ Yes ☐ No If yes, then how many? _____

If any relatives have every had any of the following, please check box and indicate relationship:

☐ Adopted ☐ History unknown

☐ Bleeding Tendency _____

☐ Cancer _____

☐ Diabetes _____

☐ Heart Disease _____

☐ High Blood Pressure _____

☐ Kidney Disease _____

☐ Stroke _____

SOCIAL HISTORY

Are/have you been a smoker? ☐Yes ☐No If yes, how many packs per day: ☐ .25 ☐ .5 ☐ 1 ☐ 1.5 ☐ 2

If not a smoker anymore, when did you quit? _____

How long have you been smoking?_____Month(s)_____Year(s)

Have you considered quitting? ☐ Yes ☐ No

Do you drink Alcohol: ☐ Yes ☐ No Drinks per Week: ____Glasses of Wine ____ Cans of Beer ____Drinks containing .5oz of Liquor

Do you exercise routinely? ☐ Yes ☐ No If yes, how many days per week do you exercise? _____

Do you have any family members living at home? ☐ Yes ☐ No Relationship: _____

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REVIEW OF SYSTEMS

General

☐ Fatigue ☐ Fever ☐ Unplanned Weight Change ☐ Weakness

HEENT

☐ Vision Loss ☐ Blurred/Double Vision ☐ Hearing Loss ☐ Ear Pain ☐ Nose Bleeds ☐ Hoarse Voice

Cardiac

☐ Chest Pain ☐ Palpitations ☐ Heart Murmur

Respiratory

☐ Cough ☐ Shortness of Breath ☐ Wheezing

Reproductive

☐ Last Menstrual Period _____ ☐ Post-menopause

GI/GU

☐ Heartburn ☐ Nausea ☐ Reflex ☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ Recurrent UTI ☐ Incontinence ☐ Painful Urination

Skin

☐ Changes in Color ☐ Dryness ☐ Lesions ☐ Wounds

Musculoskeletal

☐ Joint Pain ☐ Back Pain ☐ Neck Pain ☐ Muscle Weakness ☐ Swelling ☐ Stiffness ☐ Swollen Joints ☐ Decreased Range of Motion

Neurological

☐ Headaches ☐ Memory Loss ☐ Numbness/Tingling ☐ Fainting ☐ Dizziness ☐ Depression/Anxiety ☐ Seizures