

Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

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

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

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: _____

MEDICAL HEALTH HISTORY

Today's Date:	PCP:
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PATIENT INFORMATION

Patient's Last name:	First:	MI:
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Work Injury?	Date of Injury?	Height:	Birth date:	Sex:
<input type="checkbox"/> Yes <input type="checkbox"/> No		Weight:		<input type="checkbox"/> M <input type="checkbox"/> 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-

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*

*History of Falls-

*

*

*Flu-

*

*Pneumonia-

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 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

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: _____

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: _____

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

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