

PATIENT REGISTRATION AND INFORMATION FORM

(PLEASE PRINT)

PATIENT

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE# _____ CELL PHONE# _____ EMAIL ADDRESS: _____

D.O.B. _____ S.S. # _____ SEX (M/F) _____ MARITAL STATUS _____

EMPLOYER: _____ WORK PHONE # _____

IN CASE OF EMERGENCY PLEASE CONTACT _____ PHONE# _____

REFERRED BY _____ PHONE# _____

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR

FATHER/GUARDIAN NAME _____ D.O.B. _____ S.S.# _____

ADDRESS (if different from patient's) _____

CITY _____ STATE _____ ZIP _____ HOME PHONE# _____

EMPLOYER: _____ WORK PHONE # _____

MOTHER/GUARDIAN NAME _____ D.O.B. _____ S.S.# _____

ADDRESS (if different from patient's) _____

CITY _____ STATE _____ ZIP _____ HOME PHONE# _____

EMPLOYER: _____ WORK PHONE # _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED NAME _____ S.S.# _____ D.O.B. _____

POLICY ID#: _____ GROUP # _____

SECONDARY INSURANCE _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED NAME _____ S.S.# _____ D.O.B. _____

POLICY ID#: _____ GROUP # _____

I authorize the release of any medical information necessary to process this claim. Signature _____ Date _____	I authorize payment of medical benefits to my physician or supplier for services provided. Signature _____ Date _____
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NAME _____ DOB _____ DATE _____

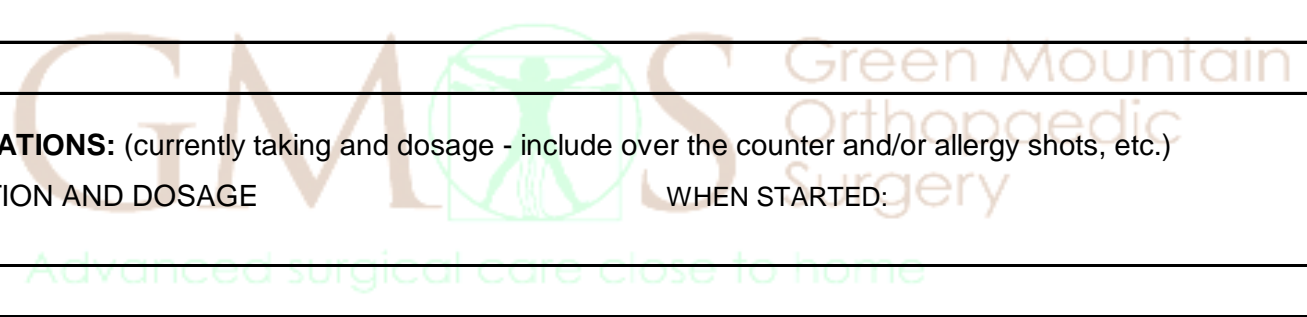
HEIGHT _____ WEIGHT _____

1. CHIEF COMPLAINT: RIGHT OR LEFT (please circle) _____

2. ALLERGIES: Y / N (please circle) DO YOU HAVE A LATEX ALLERGY? Y / N
DO YOU HAVE AN ALLERGY TO IODINE? Y / N
IF YES, PLEASE LIST ALL MEDICATIONS AND REACTION TO EACH (hives, upset stomach, etc.)

3. HOSPITALIZATIONS, SURGERIES, OR MAJOR ILLNESS (include date began if known):

4. MEDICATIONS: (currently taking and dosage - include over the counter and/or allergy shots, etc.)
MEDICATION AND DOSAGE WHEN STARTED:



5. SOCIAL HISTORY:
A. MARITAL STATUS: _____ MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED
B. HABITS (type and amount per day or week)
TOBACCO: _____ ALCOHOL: _____ CAFFEINE: _____ RECREATIONAL DRUGS: _____
EXERCISE: _____ OTHER: _____

6. HAVE YOU EVER HAD? (please circle all that apply to you)

HIV-AIDS	PHLEBITIS	MUSCLE SPASMS
HEPATITIS/LIVER DISEASE	ANEMIA	UNCONSCIOUS SPELLS
CANCER/MALIGNANCY	MIGRAINES	NIGHT SWEATS
THYROIDISM (hyper or hypo)	PARALYSIS	CONCUSSION OR HEAD INJURY
DIABETES	STOMACH ULCERS	TREMBLING OF HANDS
HEART DISEASE	RECURRENT STOMACH PAIN	PSYCHIATRIC CONDITION
ANGINA/HEART ATTACK/CHEST PAIN	NEURITIS/NEURALGIA	ALCOHOLISM/DRUG ADDICTION
HIGH/LOW BLOOD PRESSURE	ASTHMA	STROKE
BURSITIS	WEAKNESS OF HANDS OR FEET	SCIATICA
EMPHYSEMA/COPD	TINGLING OF HANDS OR FEET	BLOOD CLOT (leg and/or lungs)
KIDNEY DISEASE	MENINGITIS	ANXIETY DISORDER
FREQUENT INFECTIONS	SWELLING/PAIN IN JOINTS (WHICH JOINTS) _____	
HIGH CHOLESTEROL	GERD	
POLIO	DEPRESSION	OTHER: _____

7. ARE YOU PREGNANT? Y / N

8. REFERRING PHYSICIAN OR COMPANIES: _____

9. WHO IS YOUR FAMILY PHYSICIAN OR INTERNIST? _____

10. FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING (if yes, please state relationship):

CANCER: _____

HEART DISEASE: _____

EARLY SUDDEN DEATH: _____

KIDNEY DISEASE: _____

BLOOD CLOTS: _____

HIGH BLOOD PRESSURE: _____

OSTEOPOROSIS: _____

DIABETES: _____

STROKE: _____

11. SYMPTOMS (please check any symptoms that you are experiencing)

- | | |
|--|--|
| <input type="checkbox"/> FEVER, FEELING TIRED/POORLY | <input type="checkbox"/> ABDOMINAL PAIN |
| <input type="checkbox"/> CHILLS | <input type="checkbox"/> BLACK OR TARRY STOOLS |
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> PAIN WITH URINATION |
| <input type="checkbox"/> SORE THROAT | <input type="checkbox"/> RASH OR OTHER SKIN PROBLEMS |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> JOINT PAIN |
| <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> JOINT SWELLING |
| <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> ANXIETY |
| <input type="checkbox"/> COUGH | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> VOMITING | <input type="checkbox"/> RECENT CHANGE IN WEIGHT |

12. PAIN LEVELS

A. I WOULD DESCRIBE MY CURRENT PAIN AS:

- | | | | |
|-------------------------------------|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> DULL ACHE | <input type="checkbox"/> STIFFNESS | <input type="checkbox"/> SHARP, STABBING | <input type="checkbox"/> SHOOTING |
| <input type="checkbox"/> A NUMBNESS | <input type="checkbox"/> BURNING | <input type="checkbox"/> TINGLING | <input type="checkbox"/> OTHER _____ |

B. MY PAIN IS WORSE WITH:

- | | | | |
|---|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> LIFTING | <input type="checkbox"/> BENDING | <input type="checkbox"/> STANDING | <input type="checkbox"/> CLIMBING STAIRS |
| <input type="checkbox"/> SITTING | <input type="checkbox"/> WALKING | <input type="checkbox"/> COUGH/SNEEZE | <input type="checkbox"/> WORRY/STRESS |
| <input type="checkbox"/> SEXUAL INTERCOURSE | <input type="checkbox"/> OTHER _____ | | |

C. MY PAIN OCCURS:

- | | | |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> INTERMITTENTLY | <input type="checkbox"/> ONCE/WEEK | <input type="checkbox"/> CONSTANTLY |
| <input type="checkbox"/> ONCE/MONTH | <input type="checkbox"/> ONCE/DAY | <input type="checkbox"/> OTHER _____ |

D. MY PAIN IS BETTER WITH:

- | | | | |
|---|--------------------------------------|----------------------------------|------------------------------|
| <input type="checkbox"/> BEDREST | <input type="checkbox"/> MEDICATION | <input type="checkbox"/> HEAT | <input type="checkbox"/> ICE |
| <input type="checkbox"/> EXERCISES | <input type="checkbox"/> STANDING | <input type="checkbox"/> WALKING | |
| <input type="checkbox"/> CHANGE IN POSITION | <input type="checkbox"/> OTHER _____ | | |

NOTE: This is a confidential record of your medical history. It will be maintained as part of your file in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Signature

(Parent or Guardian if minor)

Consent to Use or Disclose Protected Health Information For Treatment, Payment and Health Care Operations

I consent to allow *Green Mountain Orthopaedic Surgery* to use or disclose my protected health information for treatment, payment and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of *Green Mountain Orthopaedic Surgery*.

I consent to allow *Green Mountain Orthopaedic Surgery* to disclose my protected health information for treatment activities of another health care provider.

I consent to allow *Green Mountain Orthopaedic Surgery* to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow *Green Mountain Orthopaedic Surgery* to disclose protected health information to another covered entity for health care operations activities, provided that *Green Mountain Orthopaedic Surgery* and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

I acknowledge that I have received a copy of *Green Mountain Orthopaedic Surgery's* Notice of Privacy.

Name of patient _____
(Please Print)

Signature of Person Authorizing Consent

Relationship to patient

Date _____

PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE PROVIDER

WE WILL ASK TO SEE BOTH YOUR INSURANCE CARD AND DRIVER'S LICENSE OR STATE IDENTIFICATION CARD ON YOUR FIRST VISIT. WE WILL SCAN YOUR CARDS INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT. WE MAY ASK FOR THIS INFORMATION ON A REGULAR BASIS IN ORDER TO ENSURE THAT NO CHANGE IN BENEFITS OR CARRIER HAS OCCURRED. PLEASE NOTIFY US IF YOUR INSURANCE CARRIER OR POLICY HAS CHANGED.

CO-PAYMENTS: Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

SELF-PAY: Self-pay accounts shall exist if a patient has no insurance coverage or evidence of insurance coverage. For new patients, a payment of \$100.00 is expected on the day of your appointment before being seen by the health care provider. A discount of regular fees is offered for payment in full at time of service.

NON-PARTICIPATING INSURANCE PLANS: As a service to our patients, we will bill as a non-assigned claim. Any outstanding balances are the responsibility of the patient.

REFERRALS: If your insurance plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, YOU MAY BE REQUIRED TO RESCHEDULE.

ACCIDENT/WORKERS COMP CASES: For any work comp and auto accident cases, it is YOUR responsibility to provide us with the date of injury, claim #, insurance company address, phone #, and contact person from the insurance company. Patients shall be financially responsible for medical services related to accident/workers comp if insurance fails to pay in full.

MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.

WE ACCEPT CASH, MASTERCARD, VISA AND CHECKS.

If you have any questions, please call the Practice Manager at 802-229-2663.

RESPONSIBLE PARTY SIGNATURE:

DATE: _____

Patient Name (if different from Responsible Party): _____