FUD:

Today's date _____/_____/_____

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

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

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

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

Social Security Number: _____ - _____- _____ Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM _____/DD _____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____

Emergency contact relationship to patient: _____ ☐ Guardian

Primary care physician information:

Name: _____ Phone number: _____

Address: _____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

How did you hear about us? Circle any that apply:

Website Family/Friend Internet Search

Former or current patient (please provide name so we can thank them!) _____

Physician (please specify): _____

Other Healthcare facility (please specify): _____

Insurance Network (please specify): _____

Other (specify): _____

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Today's date _____/_____/_____

Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

What are we seeing you for today? (Body part/Right or left):_____

Is this due to an injury?_____ When did the injury occur?_____

Do you use any of the following? Circle all that apply: Cigarettes/Cigars/Pipe/Smokeless Tobacco

If yes, how many per day? _____ Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Methamphetamine

Current Medications	Dosage

Previous Surgery	Date

Is your condition affecting your activities of daily living? ☐ Yes ☐ No

Are you allergic to any medications? Yes or No (If yes, please list.) _____

Are you allergic to any jewelry or latex? ☐ Yes ☐ No

What is your current level of pain?: 0 1 2 3 4 5 6 7 8 9 10

Have you ever had any of the following? Circle all that apply: Joint Disease / Stroke / Thyroid / Blood Clot /High Blood Pressure / Tuberculosis / Diabetes / Cancer / Heart Disease

Other:_____

Do any of these conditions run in your family? Check all that apply:

Family Member	**Diabetes**	**Lung cancer**	**Breast Cancer**	**Heart Disease**	**Joint Disease**	**Stroke**	**Blood Clot**	**Psychiatric Disorder**
Father ☐ Alive ☐ Deceased								
Mother ☐ Alive ☐ Deceased								
Sister ☐ Alive ☐ Deceased								
Brother ☐ Alive ☐ Deceased								
Other (please specify) ☐ Alive ☐ Deceased								

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Please review the following questions carefully and please answer EVERY question.

Systemic	Y N	Weight change
	Y N	Chills
	Y N	Fever
	Y N	Night sweats
	Y N	Feeling tired or poorly
Head Eyes Ear & Nose	Y N	Chronic headaches
	Y N	Eyesight problems
	Y N	Nosebleeds
Neck	Y N	Neck pain
	Y N	Neck stiffness
	Y N	Lump or swelling
Pulmonary	Y N	Shortness of breath
	Y N	Cough
	Y N	Coughing up blood
	Y N	Wheezing
Cardio-vascular	Y N	Chest pain or discomfort
	Y N	Fast heart rate
	Y N	Palpitations
Genitourinary	Y N	Blood in the urine
	Y N	Painful urination
	Y N	Increased urinary frequency
Gastrointestinal	Y N	Difficult swallowing
	Y N	Heartburn
	Y N	Nausea and/or vomiting
	Y N	Abdominal pain
	Y N	Diarrhea
Skin	Y N	Itching
	Y N	Lesions
	Y N	Rashes
Endocrine	Y N	Excessive sweating
	Y N	Excessive thirst
Psychological	Y N	Sleep disturbances
	Y N	Anxiety
	Y N	Depression
Management Following Hip, Spine or Distal Radius Fracture	Y N	Have you ever been diagnosed with a Hip Fracture?
	Y N	Have you ever been diagnosed with a Spine Fracture?
	Y N	Have you ever been diagnosed with a Distal Radius (Wrist) Fracture?
	Y N	Have you ever been diagnosed with Osteoporosis?
	Y N	Have you had a bone density test (DXA Scan) ordered or performed?
	Y N	Are you currently taking any medication(s) for Osteoporosis?
Influenza Immunization	Y N	Have you received a flu shot for the 2017-2018 Flu Season?
	Y N	Have you ever received a flu shot?
	Y N	If you have **not** received a flu shot was it for medical reasons?
	Y N	If you have **not** received a flu shot was it for non-medical reasons?
Pneumonia Vaccine	Y N	Have you ever been vaccinated for pneumonia?
	Y N	If you have **not** been vaccinated was it for medical reasons?
	Y N	If you have **not** been vaccinated was it for non-medical reasons?
Advanced Directive	Y N	Do you have an Advanced Directive or Living Will?
	Y N	If yes, who is your surrogate decision maker name and relationship?
		Name Relationship
Blood Pressure	Y N	Have you ever been diagnosed with **elevated** blood pressure (**Pre-Hypertension**)?
	Y N	Have you ever been diagnosed with **high** blood pressure **(Hypertension**)?
	Y N	Are you currently taking blood pressure medication?
Neurological	Y N	Dizziness
	Y N	Vertigo
	Y N	Motor disturbances
	Y N	Sensory disturbances
Hematological	Y N	Easy bleeding
	Y N	Easy bruising
	Y N	Blood clot or embolism

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**

All fields must be completed in order to fulfill your request

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**SSN (may use last 4 digits)**
Provider's Name: OrthoOne	**Recipient's Name:**		
Provider's Address: 799 E Hampden Ave, Suite 400 Englewood, CO 80113	**Address 1:**		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery

Paper copy will be mailed (if other arrangements need to be made, please call medical records.)

Is this request for psychotherapy notes? ☐ No, then you may check as many items below as you need.

☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

This authorization will expire on the following:

☐ This release shall expire 1 Year from the date signed or ☐ Completion of order

Purpose of disclosure:

☐ Personal use ☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Other _____

Description of information to be used or disclosed

Description:		***Description:***	***Must include Date(s) below:*** Specific date or date range
☐All medical records	**Or select specific information to the right**	☐ Physician dictation ☐ Operative information ☐ Imaging reports ☐ Testing reports ☐ Therapy ☐ Itemized bill: ☐ Other	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I can obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

Please sign and date below

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Relationship to patient:**
Print Name of Patient's Representative:	**Date:**

Authorization for Use and Disclosure of Protected Health Information (PHI)	For Official Use Only