**Patient Registration Form**

**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.

E-Mail Address:

Date of Birth MM /DD /YYYY Do you have a living will? Yes No

Sex F-Female M-Male Transgender

Race American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander Black/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 Cell No. Work Phone Ext.

**Primary Care Doctor (PCD)** Referring Provider

Referred By

**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

Email Address Sex F-Female M-Male Transgender

Address Line 1

City, State ZIP

Home Phone Cell No. Work Phone Ext.

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 I accurate and up-to-date to the best of my knowledge.***

**Patient (or Responsible Party) Signature Date**

**MEDS/PHARMACY/ALLERGIES INFORMATION SHEET**

**Patient Name: DOB:**

**Home Phone: Cell: Work:**

**Primary Care Physician: PCP Telephone:**

**Pharmacy: Location: Phone:**

**Medicine ALLERRGIES & Reactions:**

**Current Medications (both Prescriptions and Over-The-Counter):**

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Strength** | **Dosage** |
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**Patient Name: DOB:**

**Family History: Please complete to the best of your knowledge.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Member** | **Alive/Deceased** | **Age** | **List of Illness/Problems** |
| **Mother** |  |  |  |
| **Father** |  |  |  |
| **Sister(s)** |  |  |  |
| **Brother(s)** |  |  |  |
| **Children** |  |  |  |

**Social History: lease answer all questions.**

**Do you drink alcohol? If yes, how many drinks per occasion? Per week?**

**Do you smoke? How long have you smoked? Packs per day?**

**Do you drink caffeinated beverages? How many per day?**

**Do you have a history of substance/drug abuse? If yes, explain:**

**Are you on any kind of special diet? If yes what type or kind?**

**Do you exercise? If yes, what type or kind?**

**Marital Status: Single Married Separated Widowed**

**Do you have children? Do you live with (circle): Spouse, Relatives, Alone, Other**

**Are you employed? If yes, Occupation:**

**Education (circle): Jr. High School GED High School College Other**

**What is your: Weight: Height:**

**Have you seen Dr Greiner in the past? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No**

**Approximate date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Patient Questionnaire**

**PATIENT: Date of Birth:**

**REVIEW OF SYSTEMS**

**Are you currently or have you had problems with your:**

**If any are circled YES, please circle the problem and explain.**

**Yes No *Constitutional*: fever, weight loss, fatigue, development**

**Yes No *Eyes:* glasses, blurred vision, double vision, watering eyes**

***Yes No Ears, Nose, Mouth, Throat:* Earache, hearing difficulties, tinnitus, ringing. Nose Running, congestion, sneezing. Throat-sore, hoarseness, enlarged tonsils.**

**Mouth-sores, dental problems, swelling gums, sore tongue, taste changes.**

**Yes No *Cardiovascular:* blood pressure, chest pain or discomfort**

**Yes No *Respiratory:* wheezes, coughing spells, coughs up phlegm or blood, excessive or night sweats, any difficulty breathing**

**Yes No *Gastrointestinal:* heartburn, bloated stomach, belching, nausea, vomiting, constipation, diarrhea, special diet.**

**Yes No *Genitourinary:* nocturia , day frequency, burning on urination, prostate trouble**

**LMP, vaginal bleeding heavy, between periods), complications with birth control**

**Yes No *Musculoskeletal:* aching muscles or joins, swelling joints, muscle cramping or spasm, weakness**

**Yes No *Arthritis:* rheumatoid, osteoarthritis**

**Yes No *Skin (and/or breast):* skin problems, bleeds or bruises easily, hair loss, poor wound healing, night sweats, suspicious lesions**

**Yes No *Neurologic:* numbness, tingling, balance, headaches**

**Yes No *Psychiatric:* nervous, depressed, loss of memory, work or family problems**

**Yes No *Endocrine:* thyroid medication, excessive sweating**

**Yes No *Hematologic/lumphatic:* swollen nodes, excessive bruising or bleeding**

**Yes No *Allergic/Immunologic:* allergic to & list reaction**

**Yes No Disabled : How & When**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY: Please indicate any major surgeries or hospitalizations, and if there were complications.**

**Please check all that apply:**

**Medical History Surgical History**

**\_\_\_\_Anemia** \_\_\_\_**High Blood Pleasure \_\_\_\_ Aneurysm \_\_\_\_Laproscopy**

**\_\_\_\_Angina \_\_\_\_ High Cholesterol \_\_\_\_Angioplasty \_\_\_\_Lasix Eye Surgery**

**\_\_\_\_Asthma \_\_\_\_ Irritable Bowel Syndrome \_\_\_\_Appendix \_\_\_\_Mastectomy**

**\_\_\_\_Arthritis \_\_\_\_Liver Cirrhosis \_\_\_\_Arthroscopy \_\_\_\_Nerve Surgery**

**\_\_\_\_Colon Polyps \_\_\_\_Migraines \_\_\_\_Breast Biopsy \_\_\_\_Prostate**

**\_\_\_\_COPD \_\_\_\_Osteoporosis \_\_\_\_Cataracts \_\_\_\_Rotator Cuff**

**\_\_\_\_Depression \_\_\_\_Sleep Apnea \_\_\_\_Colon Resection \_\_\_\_Spine**

**\_\_\_\_Diabetes \_\_\_\_Stomach Ulcer \_\_\_\_Fracture \_\_\_\_Tonsil/Adenoids**

**\_\_\_\_Dizziness \_\_\_\_Stroke \_\_\_\_Gallbladder \_\_\_\_Total Joints**

**\_\_\_\_Emphysema \_\_\_\_Thyroid Disease \_\_\_\_Heart Bypass \_\_\_\_Tubal Ligation**

**\_\_\_\_Gout \_\_\_\_List Cancers (blelow) \_\_\_\_Hysterectomy \_\_\_\_Other (list below)**

**\_\_\_\_Hearing loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_Heartburn \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_Heart Failure (CHF)**

**Greiner Orthopedics Practice Consent**

**Notice of Privacy Practices**

I acknowledge that I have received the practice’s Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information of its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider’s business associates. To the extent permitted by law I consent to the use and disclosure of my information for the purposes described in the practice’s Notice of Privacy Practices.

**Release of Information**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Healthcare information regarding a prior admission(s) at any affiliated facilities may be made available to subsequent any affiliated admitting facilitates to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient’s behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes’ and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes the information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including but not limited to, blood borne diseases, such as HIV and AIDS.

**IMPORTANT**

**Disclosures to Friends and/or Family Members**

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have relationship.

***IMPORTANT***

**Text/ Voice/ Email Communication from our practice**

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

We want to stay connected with our patients.

Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

(\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is.

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The patient is acknowledging that any imaging brought in for a visit will only be held for 7 business days, then it will be permanently destroyed. Greiner Orthopedics is not responsible to for this part of your medical record.

The patient is acknowledging that the practice only prescribes narcotic pain medication up to 90 days after surgery, if further pain control is needed the patient will need to contact their primary care provider for further pain management.

Greiner Orthopedics does not refill any pain medications after normal clinic hours or on the weekend, allow 24 hours for any refill request to be addressed.

**Prescription Pick-up**. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician’s office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_