ORTHOPAEDIC SURGEONS OF OAK RIDGE

PATIENT REGISTRATION

Date:__________________Acct#:_________________Dr.______________________

Patient Name:____
Last First Middle Maiden Name

Address:____
Street City State Zip Code

PATIENT INFORMATION

Home Phone: (____) ____-______ Cell Phone: (____) ____-______

SS#:___________________Birthdate:___/___/___Age:_______Sex:____M ____F

Employer:_______________________________Work Phone: (____) ____-______

Occupation:____

Work Address:____

Referring Dr.____________________Injury or Complaint_____________________

Date of Injury or Onset:____________________________ _____Right _____Left

Type of accident: Auto_____ Workers Comp_____ Other_____________________

INSURANCE INFORMATION

Spouse or Parent:_____________________DOB:____/____/____ SS#:___________________

Employer:____Work Phone:________________

Work Address:____

EMERGENCY CONTACT:____

Spouse or Parent:_____________________DOB:____/____/____ SS#:___________________

Employer:____Work Phone:________________

Work Address:____

HIPAA REGULATIONS

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I,____________________have been presented a copy of the Southeastern Orthopaedics/ Orthopaedic Surgeons of Oak Ridge on_____________________(today's date).

Parent, Legal Guardian, Patient Representative:__________________________________

Relationship to Patient:____

Designated Representatives:
The following people may call to ask and receive medical information for me.

Name:_____________________________________Relationship:_______________________

Name:_____________________________________Relationship:_______________________

Name:_____________________________________Relationship:_______________________

Name:_____________________________________Relationship:_______________________

(SEE BACK)

As a courtesy to our patients, it is the policy of Orthopaedic Surgeons of Oak Ridge to file insurance claims for our patients. We request that payment be made for services rendered on a per visit basis.

I understand that I am financially responsible for the charges incurred for services and supplies received from Orthopaedic Surgeons of Oak Ridge.

I authorize Orthopaedic Surgeons of Oak Ridge to perform treatment deemed by the physician in exercise of professional judgment to be of appropriate kind and method on me/my dependent.

I authorize Orthopaedic Surgeons of Oak Ridge to release to my insurance companies or their intermediaries any medical or other information needed for this claim.

I authorize payment of medical benefits to Orthopaedic Surgeons of Oak Ridge.

Signature:____Date:_______________
(patient or legal guardian)

Orthopaedic Surgeons of Oak Ridge physicians have ownership interests in Advanced Family Surgery Center, SEO Imaging Centers and SEO Therapy Centers. You may be referred to one of these facilities for necessary medical services. You, as the patient, are free to choose to use these facilities or seek these medical services elsewhere. If you object to using these associated resources, please advise your physician and you will be referred to another comparable facility.

You may visit our website at: www.osorortho.com

TELEPHONE MESSAGE RELEASE

I give permission for this office to call my home or work number that I have listed below. You can leave test results, appointment information, and other information pertaining to me to anyone answering the telephone or on an answering machine.

______Yes ______No

My home number is: (______) ______-____________.

My work number is: (______) ______-____________.

Patient Information Form

(To be filled out by the patient)

NAME:____ AGE:_______ DATE:________________

DATE OF BIRTH:____________________________ HT: ______________ WT:______________MALE/FEMALE

RIGHT HANDED:____________ LEFT HANDED:____________ AMBIDEXTROUS:____________

OCCUPATION:________________________________ REFERRING PHYSICIAN:__________________________

Is this visit due to an injury? YES_____ NO_____ DATE: ______________________________________

Was the injury work related? YES_____ NO_____ DATE:____

MEDICAL HISTORY **(please check all that applies)**

HEART

- ❑ Hypertension
- ❑ Heart Murmur
- ❑ Arrhythmia
- ❑ Chest Pain
- ❑ MI
- ❑ Stroke/TIA's
- ❑ Congestive Heart
- ❑ Congenital Heart Disease

OTHER

- ❑ HIV/Hepatitis
- ❑ Depression
- ❑ Rheumatoid Arthritis
- ❑ Osteoporosis
- ❑ Arthritis

LUNGS

- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Pneumonia
- ❑ Emphysema
- ❑ Tuberculosis

OTHER

- ❑ Blood thinners
- ❑ Smoke/Chew, if so how much______
- ❑ Alcohol (never) (occ.) (daily)
- ❑ Epilepsy/Seizure
- ❑

GI/KIDNEY

- ❑ Ulcer
- ❑ Hiatal Hernia
- ❑ Gastritis
- ❑ Hepatitis
- ❑ Cirrhosis of Liver
- ❑ Kidney Infection

ENDOCRINE

- ❑ Diabetes
- ❑ Insulin Dependent
- ❑ Oral Agent
- ❑ Diet Controlled
- ❑ Hypoglycemia
- ❑ Hypothyroidism
- ❑ Hyperthyroidism

SURGERY

- ❑ Hysterectomy
- ❑ Tonsillectomy
- ❑ Gallbladder
- ❑ Appendectomy
- ❑ Heart Bypass
- ❑ Stints
- ❑ Cataract
- ❑ CABG
- ❑ C-section

MRI

- ❑ Q-ports
- ❑ Pain patches
- ❑ Cancer
- ❑ Previous MRI
- ❑ Defibrillator
- ❑ Heart Stints
- ❑ Claustrophobic
- ❑ Vascular Coils or Filters
- ❑ Anxiety
- ❑ Dentures
- ❑ Metal injury to eyes
- ❑ Aneurysm Clips
- ❑ Pacemaker
- ❑

Medical History not listed:

Surgical History not listed **including** orthopedic surgery: ____

____

CURRENT MEDICATIONS INCLUDING OVER THE COUNTER AND HERBAL: __________________________

____

Latex Allergies? Yes No Sleep Apnea: Yes No (if yes, do you use a C-Pap) Yes No

Allergies to medications: ____ No known allergies

Environmental allergies: ____

_____________________________________ _____________________________________

PATIENT/GUARDIAN SIGNATURE PHYSICIAN SIGNATURE

ORTHOPAEDIC SURGEONS OF OAK RIDGE

NEW COMPLAINT FORM

(TO BE FILLED OUT BY THE PATIENT)

NAME: ______________________________ DATE: ______________

1. BRIEFLY DESCRIBE YOUR **COMPLAINT OR INJURY**: ______________________________
   ____
2. WHEN DID THIS **OCCUR**? ______________________________
3. WHERE IS THE **LOCATION OF YOUR PAIN?** ______________________________
4. DOES YOUR PAIN **TRAVEL:** YES NO IF SO, HOW IT TRAVELS: ______________________________
5. ON A SCALE OF 1 TO 10, **RATE YOUR PAIN** (1 IS LEAST - 10 IS WORST) ______________________________
6. DESCRIBE YOUR **PAIN:**
   1. SHARP
   2. DULL
   3. ACHE
   4. THROBBING
   5. BURNING
   6. NUMBNESS
   7. WEAKNESS
   8. STIFFNESS
   9. UNSTABLE OR DISCLOCATING JOINT
   10. SWELLING
7. IS THERE **DECREASED MOVEMENT** IN THIS BODY PART? YES NO
8. WHAT **WORSENS** YOUR PROBLEM?
   1. EXERCISE
   2. SITTING
   3. STANDING
   4. WALKING
   5. REPETITIVE MOTION
   6. OVERHEAD ACTIVITIES
   7. COUGHING, SNEEZING, STRAINING
   8. REST
   9. NOTHING
   10. OTHER ______________________________
9. HAVE YOU HAD **PREVIOUS MEDICAL TREATMENT** FOR THIS? (DETAILS AND DATES)
   1. NONE
   2. YES
   3. EMERGENCY ROOM
   4. PRIMARY CARE PHYSICIAN ______________________________
   5. INJECTION, HOME EXERCISE, ICE/HEAT ______________________________
   6. PHYSICAL THERAPY ______________________________
   7. SURGERY ______________________________
   8. OTHER ______________________________
10. WHAT **TESTS** HAVE YOU HAD DONE FOR THIS PROBLEM? WHERE?
    1. X-RAY'S ______________________________
    2. CT SCAN ______________________________
    3. MRI ______________________________
    4. NERVE TESTS (EMG/NCS) ______________________________
    5. BONE SCAN ______________________________
    6. ARTHROGRAM OR MYELOGRAM ______________________________
11. LIST **MEDICATIONS** YOU ARE SPECIFICALLY TAKING FOR THIS PROBLEM:
    ____

B/P______________ **PULSE**______________ **HT.**______________ **WT.**______________

PHYSICIAN'S SIGNATURE: ______________________________