The Center for ADVANCED ORTHOPAEDICS

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name	(First)	(Middle)	SS#
Address (Street)	(Apt#) (City)	(State) (Zip)	Referred By
Home Phone # ( )	Work Phone # ( )	Date of Birth	Age / Sex ❑ M ❑ F / Race
Cell Phone # ( )	Occupation	Employer	Employer Phone # ( )
Email			
Emergency Contact	Name	Relationship to Patient	Emergency Contact's Phone # ( )

Family Physician	Doctor's Phone # ( )	Doctor's Fax # ( )
Family Pharmacy	Pharmacy Phone # ( )	Pharmacy Fax # ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance	Worker's Comp. Auto or Primary Insurance Company	ID/Claim #		Group #
	Full Address of Worker's Comp. Auto or Primary Insurance Company			
	If Auto or Worker's Comp, Adjuster's Name			Adjuster's Phone # ( )
	Name of Insured	Date of Birth	SS #	Relationship to Patient
	Condition or Injury is related to ☐ Work ☐ Auto ☐ Other Accident	Date of Injury	Last Day Worked	
Secondary Insurance	Secondary Insurance Company	ID #		Group #
	Name of Insured	Date of Birth	SS #	Relationship to Patient

PRESENT CONDITION

What problem has brought you here today?

If accident, please state where accident occurrred:

Have you been treated for this condition or Body Part prior to today's visit?
☐ No ☐ Yes - name of physician/hospital: ______________________________

Any MRI for present condition? (when, where) ______________________________

Any X-rays for present condition? (when, where) ______________________________

PAST MEDICAL HISTORY

Please check if you have had any of the following

- ☐ Arthritis/Gout (circle)
- ☐ Stroke
- ☐ Hearing Loss
- ☐ Neck/Back Pain (circle)
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Fracture/Dislocation
- ☐ AIDS or HIV Positive
- ☐ Excessive Bleeding
- ☐ Stomach Ulcers
- ☐ Blood Disorders
- ☐ Auto Accident
- ☐ Work Injury
- ☐ Hernia
- ☐ Blood Transfusion
- ☐ High Blood Pressure
- ☐ Gall Bladder Disease
- ☐ Anemia
- ☐ Diabetes
- ☐ Hepatitis – Type: ______
- ☐ Venereal Disease – Type: ______________
- ☐ Cancer – Type: ______________
- ☐ Kidney Disease
- ☐ Anxiety/Depression (circle)
- ☐ Radiation Therapy
- ☐ Kidney Stones
- ☐ Weight Gain/Loss (circle)
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Skin Disease
- ☐ Rheumatic Fever
- ☐ Headaches – Type: ______________
- ☐ Asthma
- ☐ Seizures – Type: ______________
- ☐ Mitral Valve Prolapse
- ☐ Surgery – Type: ______________
- ☐ Other ______________

____

MEDICATION AND ALLERGIES

☐ No Known Allergies Allergies:

Latex allergy: ☐ Yes ☐ No

☐ Taking medications (INCLUDE HERBALS, HOMEOPATHICS, AND VITAMINS. list name, dose, and frequency):

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

FAMILY MEDICAL HISTORY

Please check if your parents, grandparents, brothers or sisters have had problems with:

☐ Arthritis/Gout
☐ Heart Disease
☐ Hepatitis/Liver Disease (circle one) Hep Type: ______________
☐ Thyroid Disease
☐ High Blood Pressure
☐ Asthma
☐ Kidney Disease
☐ Anemia
☐ Diabetes
☐ Stroke
☐ Seizures - Type: _________
☐ Anxiety/Depression (circle one)
☐ Cancer
☐ Bleeding Disorders
☐ Alcohol/Drug Abuse (circle one)
☐ Other ____

SOCIAL HISTORY

☐ Substance Abuse – Type:

☐ Recreational Drugs – Type:

Do you smoke? ☐ Yes _____ packs/day ☐ No

Do you drink alcohol? ☐ Yes: how often? __________ ☐ No

REVIEW OF SYMPTOMS

(Circle all that apply)

Eyes, Ears, Nose, Throat	Headaches • Blurry/double vision • Hearing loss Lightheadedness • Dizziness • Trouble Swallowing	Other
Cardio	Chest pain • Chest tightness • Palpitations	Other
Pulmonary	Shortness of breath • Wheezing • Cough	Other
Gastro Intestinal	Abdominal discomfort • Nausea/vomiting • Constipation Diarrhea • Blood in stool • Appetite/weight change	Other
Gastro Urological	Frequent urination • Difficulty urinating	Other
Neurological	Numbness • Tingling • Burning sensation • Poor Balance Body part: ____________________	Other
Musculoskeletal	Fatigue • Weakness • Joint pain/aches • Swelling Body Part: ___________________	Other

Check one: ☐ Right-handed ☐ Left-handed
Height: ________
Weight: ________

Office Use Only: Blood Pressure: ________ Temp: _______ Pulse: __________