

**ORTHOPAEDIC SPECIALISTS OF NORTH CAROLINA**

**PATIENT REGISTRATION FORM**

Date \_\_\_\_\_ Chart # \_\_\_\_\_

Patient \_\_\_\_\_ Preferred Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Sex: Male or Female

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_

DOB: \_\_/\_\_/\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: B W A H Other \_\_\_\_\_ Marital Status: M S D Sep W

Employer Name and Address: \_\_\_\_\_

In case of an emergency, who should we contact? \_\_\_\_\_

Name	Phone	Relationship
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Who referred you to our office? \_\_\_\_\_

Name	Address	Phone
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Who is your Primary Care Physician? \_\_\_\_\_

Name	Address	Phone
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**Primary Insurance Information:**

Name of Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder's Employer and Address \_\_\_\_\_

Policy Holder's DOB \_\_/\_\_/\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Insurance Information:**

Name of Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder's Employer and Address \_\_\_\_\_

Policy Holder's DOB \_\_/\_\_/\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Worker's Compensation Information:**

Name of Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Date of Injury \_\_/\_\_/\_\_ Employer at time of accident \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension \_\_\_\_\_

I consent to treatment necessary for the care of the above named person for whom I am legally responsible. I authorize the release of all medical records to the referring or primary care physician, or to other physicians as required for treatment and to my health insurance company, if applicable. I authorize transmission of medical information by fax. Any other release of medical information with necessitate a specific written authorization by me. I authorize any health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I acknowledge full financial responsibility for services rendered by Orthopaedic Specialists of NC. I understand that payment of charges incurred is due at the time of service unless other defined financial arrangements have been made prior to treatment. I further authorize and request that insurance payments be made directly to Orthopaedic Specialists of NC. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Seal)

I have received ORTHOPAEDIC SPECIALISTS OF NC'S Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

ORTHOPAEDIC SPECIALIST OF NORTH CAROLINA  
"NO SHOW POLICY"

Effective May 1, 2007

In an effort to provide all the patients of Orthopaedic Specialists of North Carolina (OSNC) with the best patient care and most accurate scheduling possible, it is our policy to charge insured and non-insured patients a "no show" fee for missed appointments as outlined below:

"No-Show" is defined as an appointment not canceled within 24 hours of scheduled appointment.

1<sup>st</sup> "No-Show"- Patient will be contacted by clinical staff to follow -up on medical condition and reschedule appointment as necessary NO Charge.

2<sup>nd</sup> "No-Show"- Patient will be contacted by clinical staff to follow -up on medical condition and reschedule appointment as necessary. \$10.00 will be charged to patient account and must be paid at next appointment at check-in prior to appointment.

3<sup>rd</sup> "No-Show"- Patient will be contacted by clinical staff to follow-up on medical condition. \$10.00 fee will be charged to patient account. Patient must come in and pay fee and make appointment in person (or by phone with credit card). Patient will be sent certified letter stating that they have been flagged as a "habitual no-show" and another "no-show" may result in dismissal.

I have read and understand the above policy.

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Patient (Guardian)

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Date



Date:		Referring MD:
Name:		Family Physician:
Date of Birth:	Age:	Occupation:
Sex: M F	Race:	Employer:

**HISTORY (4, 4, 4 elements)**

Dominant Hand: RIGHT LEFT BOTH	Work related: YES NO
Date of Injury/Onset:	Need return to work form: YES NO
Body part involved:	Last full day of work:

How injury occurred:
What improves the pain:
What worsens the pain:
Level of pain: 0 1 2 3 4 5 6 7 8 9 10 (0 is none and 10 is as bad as it can get.)

**REVIEW OF SYSTEMS (2-9, 10, 10)**

Medical Illness (check all that apply)

**General:**

- Unexplained weight loss
- Unexplained weight gain
- Fever/Night sweats
- Loss of Energy/tired

**Endocrine:**

- Hot/Cold intolerance
- High blood sugar
- Rapid heart beat
- Excessive thirst
- Frequent urination

**Hematology:**

- Low blood count
- Blood clots
- Easy bruising

**Psychiatric:**

- Anxiety
- Depressed mood/thoughts
- Excessive nervousness

**Respiratory:**

- Wheezing/asthma
- Productive/chronic cough

**Skin:**

- Unexplained skin changes

**GU:**

- Loss of bladder control
- Kidney stones
- Increased frequency

**GI:**

- Nausea/vomiting
- Diarrhea
- Change in bowel habits

**ENT:**

- Change in vision
- Headaches
- Voice changes
- Frequent colds
- Dental problems

**Circulatory:**

- Varicose veins
- Inflammation of vessels
- Change in hand/foot color or temp.

**Neurologic:**

- Seizures
- Loss of memory

**Cardiac:**

- Chest pain
- Shortness of breath
- High blood pressure

Please explain all positive responses below AND any health issues not listed:

HISTORIES: 1, 3, 3

**1. PAST MEDICAL HISTORY:** Please list all prior and current illnesses and injuries

**DRUG ALLERGIES:** Please list all

**PRIOR SURGERIES:** Please list procedure and approximate date

**CURRENT MEDICATION:**

**2. FAMILY HISTORY:** Please list any family illnesses

**3. SOCIAL HISTORY:**

MARITAL STATUS:  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED

LIVING ARRANGEMENTS:  Independent or with Spouse  With Family  Assisted Living  
 Nursing Home  Other

ACTIVITY LEVEL:  Independent (no limits)  Community activities only  House bound

DO YOU SMOKE?  YES  NO  PRIOR USE

If yes, smoked \_\_\_\_\_ cigarettes/packs for \_\_\_\_\_ years

DO YOU CONSUME ALCOHOL?  YES  NO  PRIOR USE If yes amount: \_\_\_\_\_

Any other comments on your general health:

\_\_\_\_\_  
Patient signature and date

Email (optional): \_\_\_\_\_

# Orthopaedic Specialists of NC

## BODY DIAGRAM (FEMALE)

Mark The Areas On Your Body Where You Feel The Described Sensations. Use The Appropriate Symbol. Mark Areas Of Radiation. Include All Affected Areas.

Weight \_\_\_\_\_

Height \_\_\_\_\_

Numbness = = =

Burning X X X

Pins & Needles o o o

Stabbing // // //

