

**ORTHOPAEDIC SPECIALISTS OF NORTH CAROLINA
PATIENT REGISTRATION FORM**

Chart # _____

Date _____

Patient _____ Preferred Name _____
Last Name First Name MI
 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

Who referred you to our office? _____
Name Address Phone

Who is your Primary Care Physician? _____
Name Address Phone

Primary Insurance Information:

Name of Company _____ City _____ ST _____ Zip _____
 Address _____ Relationship to Patient _____

Policy Holder's Name _____
 Policy Holder's Employer and Address _____
 Policy Holder's DOB ____/____/____ SS# ____/____/____ ID# _____ Group# _____

Secondary Insurance Information:

Name of Company _____ City _____ ST _____ Zip _____
 Address _____ Relationship to Patient _____

Policy Holder's Name _____
 Policy Holder's Employer and Address _____
 Policy Holder's DOB ____/____/____ SS# ____/____/____ ID# _____ Group# _____

Worker's Compensation Information:

Name of Company _____ City _____ ST _____ Zip _____
 Address _____

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.

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

2nd "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.

3rd "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.

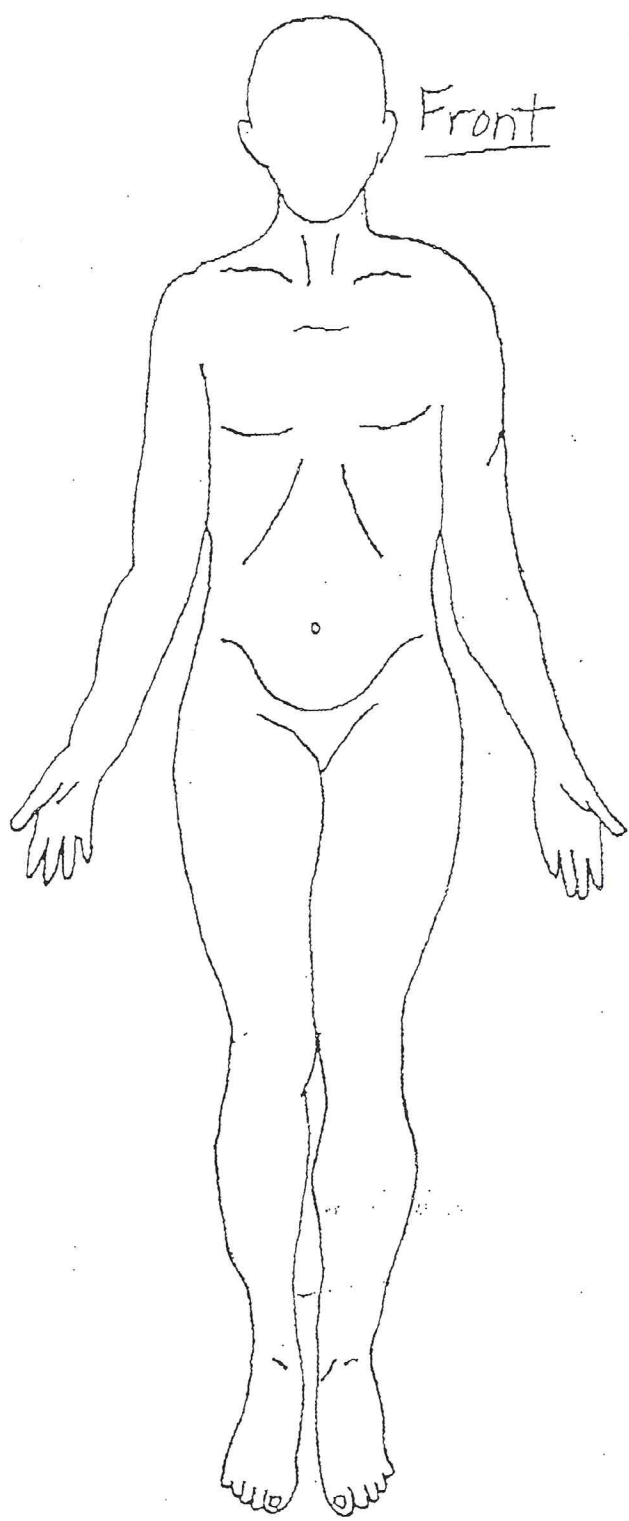
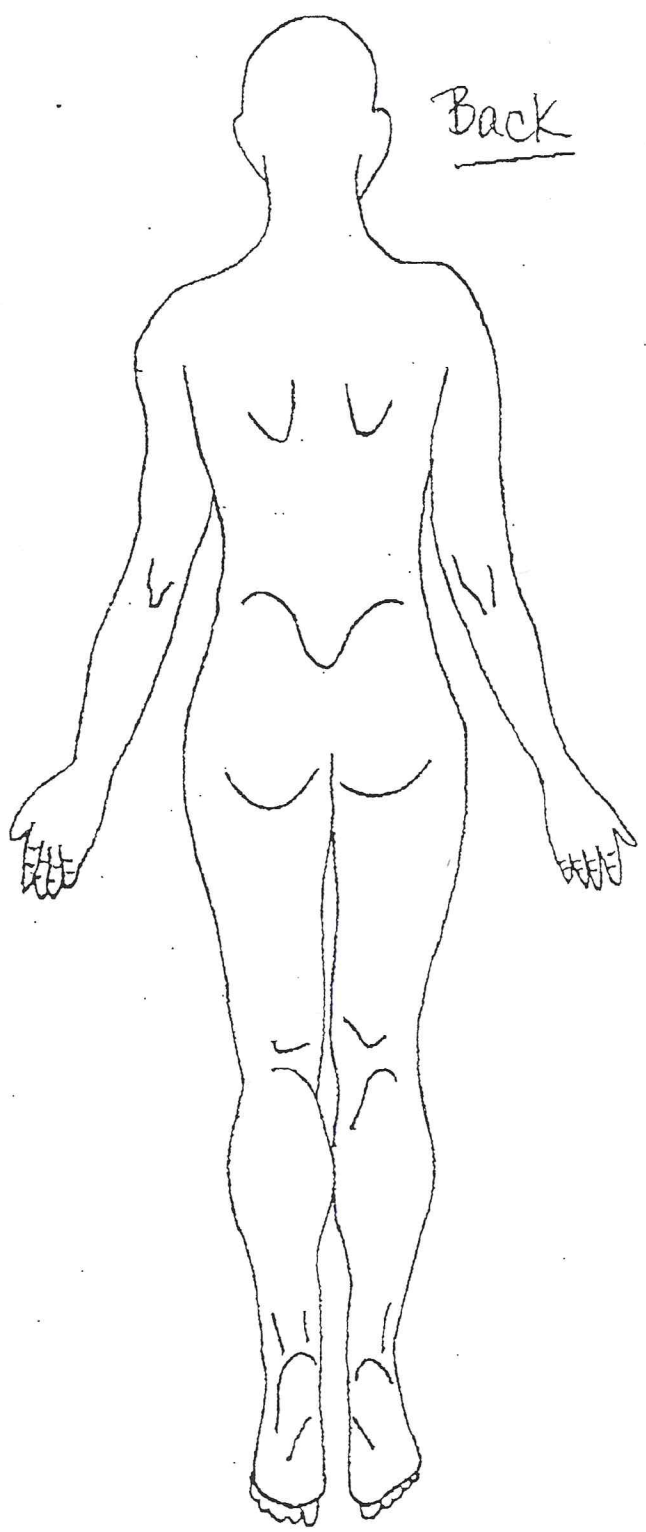
Patient (Guardian)

Date

DATE: _____

NAME: _____

CHART # _____



INSTRUCTIONS: SHADE IN THE AREAS WHERE YOU HAVE PAIN.
 MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE
 THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.

- | | | | | | | | |
|----------|-------|----------------|-------|---------|-------|----------|-------|
| numbness | = = = | PINS & NEEDLES | o o o | Burning | x x x | Stabbing | l l l |
| " " " | " " " | " " " | o o o | " " " | x x x | " " " | l l l |
| " " " | " " " | " " " | o o o | " " " | x x x | " " " | l l l |

New Patient Questionnaire for Dr. Paul B. Suh, MD

Name: _____ Today's Date _____

Age: _____

- 1) Why are you seeing the doctor today?
- 2) How long have you had this problem?
- 3) Did anything cause this problem (i.e. an accident or specific event)?
- 4) What have you tried to help alleviate your symptoms (i.e. any medications, physical therapy, injections, etc)?

- 5) What makes your symptoms worse?

Sneezing	Walking _____ minutes
Coughing	Standing _____ minutes
Straining	Sitting _____ minutes
Bending	Other _____
Lifting	

- 6) What makes your symptoms better?
 - Rest
 - Medications
 - Exercise/activity
 - Change in Position
 - Other _____

- 7) Describe how your symptoms affect your daily activities (i.e. work, household, recreational activities)?

8) Have you had any previous diagnostic studies?

Location

Date

MRI: _____

X-rays: _____

CT scan: _____

Other: _____

9) Have you had previous spinal surgery? If yes, what have you had done?

10) Do you have any other medical problems that you are treated for?

11) Are you taking any medications? If yes, please list

12) Do you smoke?

Amount/number years _____

If you previously smoked, how much did you used to smoke and when did you quit? _____

Do you use any other tobacco products? _____

13) Do you drink alcohol? _____ If yes, how much _____

14) Any street drug use? _____ If yes, what _____

15) Are you allergic to any medications, dyes or foods? If yes, please list.

16) Have you had any non-spinal surgeries? If yes, please list

17) Do you have a family history of any illnesses?

18) Please provide the following social information:

Martial Status: Single Divorced Married Partnered Widowed

Race _____

Highest Level of Education _____

Occupation _____

Are you continuing to work at present? _____

Have you had to reduce you work hours due to your

symptoms? _____

Have you had to change your work duties due to your

symptoms? _____ If yes, how so?

Children (ages and gender): _____

19) Do you have any problems with the following? Please circle

General Health Problems:

Weight loss Weight Gain
Unexplained fever Fatigue

Endocrine problems:

High/low blood sugars Thyroid problems
Hot/cold intolerance
Other _____

Hematological problems:

Anemia Blood clots
Easy bruising/bleeding
Other _____

Psychiatric problems:

Depression Anxiety
Suicidal thoughts
Other _____

Skin problems: Recent changes in hair, nails or skin

Other _____

Vision or eye problems:

Blurred vision Double vision
Excessive burning/tearing
Other _____

Nasal or sinus problems: Frequent colds/ nasal drainage Unexplained headaches

Other _____

Mouth, dental or voice problems _____

Heart/Lung problems:

Chest pain Palpitations
New cough, coughing blood Shortness of breath
Wheezing
Other _____

Blood Vessel problems:

Change in color of your toes History of varicose veins/phlebitis
Other _____

Gastrointestinal Problems:

Nausea/vomiting Diarrhea
Change in bowel habits
Other _____

Urinary Problems:

Incontinence Frequency
Hesitancy Kidney stones
Other _____

Neurological Problems:

Headache Seizures
Memory Loss
Other _____