

**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:	Referring MD:
Name:	Family Physician:
Date of Birth:	Age:
Sex: M F	Race:
	Occupation:
	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): _____