

Performance Orthopaedics & Sports Medicine

Patient Registration Form

TODAY'S DATE _____

Updated: _____

PATIENT INFORMATION

DATE OF BIRTH: ____/____/____ GENDER: MALE FEMALE SOC SEC #: ____-____-____
MM DD YYYY

FULL NAME: _____ HOME PH #: _____
LAST FIRST MI

ADDRESS: _____ WORK PH #: _____
CELL PH #: _____

CITY STATE ZIP

EMPLOYER / SCHOOL NAME: _____

MARITAL STATUS: S M D W PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____ PH #: _____
LAST FIRST MI

PREFERRED PHARMACY (name & location): _____

HOW DID YOU LEARN ABOUT US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

INS. PLAN NAME: _____ INS. GROUP # _____

INS. PLAN ADDRESS: _____ INS. ID # _____
(Policy Number)

INS. PLAN PH # _____

CITY STATE ZIP COPAY AMOUNT: _____

PRIMARY INSURED'S NAME: _____ PRIMARY'S DOB: ____/____/____
LAST FIRST MI MM DD YYYY

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER _____

SECONDARY INSURANCE POLICY (IF APPLICABLE)

INS. PLAN NAME: _____ INS. GROUP # _____

INS. PLAN ADDRESS: _____ INS. ID # _____
(Policy Number)

INS. PLAN PH # _____

CITY STATE ZIP COPAY AMOUNT: _____

PRIMARY INSURED'S NAME: _____ PRIMARY'S DOB: ____/____/____
LAST FIRST MI MM DD YYYY

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER _____

PRESENT HEALTH

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

GENERAL HEALTH:	<input type="checkbox"/> None	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of appetite
	Females: <input type="checkbox"/> Pregnant				
EYES:	<input type="checkbox"/> None	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Double vision	<input type="checkbox"/> Severe Redness	
EARS:	<input type="checkbox"/> None	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Dizziness
NOSE:	<input type="checkbox"/> None	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sinus pain/pressure
MOUTH/THROAT:	<input type="checkbox"/> None	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Problems swallowing	<input type="checkbox"/> Sores in mouth	<input type="checkbox"/> Tooth pain <input type="checkbox"/> Hoarseness
CHEST/HEART:	<input type="checkbox"/> None	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Racing/pounding heart	<input type="checkbox"/> Leg pain/limp w/ walking	<input type="checkbox"/> Problems breathing w/ lying down
RESPIRATORY:	<input type="checkbox"/> None	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Coughing up blood or mucus w/ blood
STOMACH:	<input type="checkbox"/> None	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Vomiting up blood
BOWELS:	<input type="checkbox"/> None	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Black/bloody stools	<input type="checkbox"/> Unusual change in stool size/shape/color
URINARY TRACT:	<input type="checkbox"/> None	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Increased urination	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Pain w/ urination <input type="checkbox"/> Waking to urinate
MUSC/SKEL:	<input type="checkbox"/> None	<input type="checkbox"/> Back pain	<input type="checkbox"/> Pain in muscles/joints	<input type="checkbox"/> Limited range of motion in joints	
SKIN:	<input type="checkbox"/> None	<input type="checkbox"/> Rash	<input type="checkbox"/> Redness	<input type="checkbox"/> Sores	<input type="checkbox"/> Changing moles/warts or other lesions
NEUROLOGICAL:	<input type="checkbox"/> None	<input type="checkbox"/> Seizures	<input type="checkbox"/> Problems w/ coordination	<input type="checkbox"/> Memory/Sensory issues	<input type="checkbox"/> Weakness/numbness/tingling
ENDOCRINE:	<input type="checkbox"/> None	<input type="checkbox"/> Unusual changes w/ skin or hair		<input type="checkbox"/> Increased sensitivity to temperature changes	
BLOOD:	<input type="checkbox"/> None	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Frequent nosebleeds	<input type="checkbox"/> Swollen hands/feet	<input type="checkbox"/> Swollen glands <input type="checkbox"/> Unusual bruising
IMMUNE:	<input type="checkbox"/> None	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Frequent sinus/ear or respiratory infections	
MENTAL HEALTH:	<input type="checkbox"/> None	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Emotional changes	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Thoughts of hurting self or others

RISK FACTORS: (all information is considered protected information under HIPAA guidelines)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> HEPATITIS (type) _____ | <input type="checkbox"/> IV DRUG USE |
| <input type="checkbox"/> OCCUPATIONAL EXPOSURE | <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> TRANSFUSION (Before 1980) | <input type="checkbox"/> HISTORY OF PREVIOUS STD (type) _____ | |

PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS

Please list any surgeries or illnesses you have had in the past:

SURGERY OR ILLNESS	HOSPITAL	YEAR

ALLERGIES

Are you **allergic** to any medications or other substances? **Y** **N** If yes, please list item and reaction(s) below:

Medication	Reaction
Other Allergies	Reaction

CURRENT MEDICATIONS

Please list any medications you are taking, and the dosage, frequency, and reason prescribed below:
 (Example: Zantac, 150mg, once a day, heartburn)

Medication	Dosage	Frequency	Reason prescribed

TESTS PERFORMED

***Please check off tests that you may have had that relate to the current problem(s) you are having.

<input type="checkbox"/> X-ray	<input type="checkbox"/> Injections	<input type="checkbox"/> MRI	<input type="checkbox"/> CT Scan	<input type="checkbox"/> EMG
Date	Date	Date	Date	Date
<input type="checkbox"/> PT	<input type="checkbox"/> Myelogram	<input type="checkbox"/> Discogram	<input type="checkbox"/> Other	<input type="checkbox"/> Other
Date	Date	Date	Date	Date

PAIN MODALITIES & LEVEL

<input checked="" type="checkbox"/> All that apply		
<input type="checkbox"/>	Staying the same	Pain Scale _____ (1-very little pain / 10-severe pain)
<input type="checkbox"/>	Getting Worse	
<input type="checkbox"/>	Getting Better	
<input type="checkbox"/>	Numbness	Location of Numbness _____
Sitting	<input type="checkbox"/> Increase Pain	<input type="checkbox"/> Decrease Pain
Standing	<input type="checkbox"/> Increase Pain	<input type="checkbox"/> Decrease Pain
Walking	<input type="checkbox"/> Increase Pain	<input type="checkbox"/> Decrease Pain
Driving	<input type="checkbox"/> Increase Pain	<input type="checkbox"/> Decrease Pain
Sleeping	<input type="checkbox"/> Increase Pain	<input type="checkbox"/> Decrease Pain
Lifting	<input type="checkbox"/> Increase Pain	<input type="checkbox"/> Decrease Pain
Physical Therapy	<input type="checkbox"/> Increase Pain	<input type="checkbox"/> Decrease Pain
Limits Active Daily Life	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	How: _____