G2 ORTHOPEDICS AND SPORTS MEDICINE
LIFE BACK IN MOTION

Patient Registration Form

☐ ☐ ☐ ☐ ☐ ☐

Dr. Mr. Mrs. Ms. Jr. Sr. Patient's Name: (Last)_____(First)_____ (M.I.)_____

Social Security Number:_____ Female ☐ Male ☐ DOB:_____

Marital Status: (Circle One) ◉ Married ○ Single ○ Divorced ○ Widowed ○ Legally Separated

E-Mail Address:_____ Employer:_____

Phone Numbers: Work: _____ Home: _____ Cell: _____

Street Address: _____City, State, Zip_____

Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

RESPONSIBLE PARTY– If Different from Above: Patient Relationship to Responsible Party_____

Responsible Party Name:(L)_____(F)_____(MI)____

Social Security Number:_____Female ☐ Male ☐ DOB: _____

E-Mail Address:_____ Employer:_____

Phone Numbers: Work: _____ Home: _____ Cell:_____

Street Address: _____City, State, Zip _____

Read and Initial Each Item Below

__ I agree that the information suppplied in this form are up to date to the best of my knowledge

__ I have read the **G2 Orthopedics and Sports Medicine Notice of Privacy Practices.**

__ I acknowledge that if I have questions or complaints that I should contact the Facility Privacy Official.

__ I understand that I am financially responsible for all charges resulting from treatment.

Consent for Treatment and Billing

I consent to the use of disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I have the right to revoke this consent, in writing, at any time, except to the extent that G2Orthopedics has acted in reliance on this consent.

Patient Name_____ Signature_____ Date_____

Guardian(Minors)_____Signature_____Date_____

G2 Representative_____ Date_____

Page Intentionally Left Blank

G2 ORTHOPEDICS AND SPORTS MEDICINE
LIFE BACK IN MOTION

RELEASE OF MEDICAL INFORMATION and /or FINANCIAL INFORMATION(OPTIONAL)

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Medical (please circle)	Financial (please circle)
_____	Y N	Y N
_____	Y N	Y N

*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name_____ Signature_____ Date_____

Guardian Name (Minors)_____Signature_____Date_____

G2 Representative_____ Date_____

G2 ORTHOPEDICS AND SPORTS MEDICINE
LIFE BACK IN MOTION

Financial Policies

Most insurance plans include a deductible AND a co-insurance. This means that after you meet your deductible, you will still have a co-insurance. In some cases, there is co-payment.

Important Definitions:

1. **Copay:** A copayment or copay is a fixed payment for a covered service, paid when you receive a service. A copayment is a payment defined in an insurance policy and paid by you each time a medical service is accessed.
2. **Deductible**: The amount that you have to pay out-of-pocket for expenses before the insurance company will cover the remaining costs. For example, if you have a deductible of $500.00, you will have to meet that amount before your insurance will cover your surgery.
3. **Coinsurance:** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

- **Our office will provide an ESTIMATE of your office visit cost.**
- **Our office REQUIRES that your ESTIMATE is paid at the time of your office visit.**
- **If your insurance requires us to collect any additional amount, you will be sent a bill in the mail from our office**

INSURANCE BILLING: As a courtesy, we will bill your insurance company. It is however your responsibility to know your insurance benefits. Even if we obtain authorization for a treatment from your primary insurance, they do not guarantee that they will pay for the service. We do not contact secondary insurances.

ADDITIONAL CHARGES

- No Show Charge $35.00 if not notified within 24 hours prior to your appointment.
- Completion of Forms is subject to a $15.00 fee per 1 page forms and $25 for longer forms.
- Copy of your Medical Records is a $10.00 fee plus $0.50 per page for the first 50 pages and $0.25 per page thereafter.
- Return Check Fee $50.00

****33% plus court costs and legal fees will be added to accounts sent to collections****

I, _____, have read, understood and agreed to the above terms.
(Print Name)

_____ _____
Patient or Guardian Signature Date

Patient History

Patient Name: _____ Age: _____ Handed: Rt Lt Both

HISTORY OF PRESENT PROBLEM

1. Main reason for visit? Pain Numbness Weakness Stiffness Other_____

2. What **MAIN** body part is involved? (Reason appointment was made)

Shoulder R L **Elbow** R L **Hand** R L **Hip** R L **Knee** R L **Ankle** R L

Arm R L **Wrist** R L **Finger** R L **Foot** R L

3. The problems has been present for: ____Days **or** ____Weeks **or** ____Months **or** ____Years

4. How did your problem begin (**Onset**)?

IF NO INJURY- Began Gradually OR Started Suddenly Why do you think it started? _____

Sports Injury- Date: _____ Which sport: _____ How? Fall Twist Pull Hit Other_____

Work Injury- Date: _____ How did it occur? Lift Twist Bend Pull Reach Other _____

Other Injury- Date: _____ Describe what happened _____

5. **Severity** of pain? Mild 1 2 3 4 5 6 7 8 9 10 Severe

6. **Quality** of pain? Sharp Dull Stabbing Throbbing Aching Burning Other_____

7. **Timing** of pain? Constant Comes & goes **Does** the pain wake you from **sleep?** Yes No

8. Do you have Swelling Catching Locking Giving way Bruising Numbness Tingling Weakness

Loss of bowel or bladder control

9. Since my problem started, it is: Getting better Getting worse Unchanged

10. What makes your symptoms worse? Standing Walking Lifting Exercise Twisting Lying in bed

Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

11. What makes it better? Rest Heat Ice Elevation Other_____

12. What medications have you taken for this problem? _____

13. Which treatment have you tried? Injection Brace Therapy Cane/crutch Other: _____

14. Were you seen in an Emergency Room for this problem? N Y Which ER and date? _____

15. What tests have you had for this problem? X-rays MRI CAT scan Bone scan Nerve test

16. Have you already had surgery for this problem? N Y Surgeons Name**:** _____ Date: _____

Page Intentionally Left Blank

PATIENT MEDICAL HISTORY FORM

Patient Information

Name:

How did you hear about our Practice?

☐ Physician (specify below) ☐ Family/Friend ☐ Internet ☐ Trainer/Coach ☐ Sports League ☐ Insurance ☐ Advertising ☐ Other _____

Preferred Pharmacy:

Referral Source	☐ Referring Provider: _____	Primary Care Physician: _____
	Practice name: _____	Practice name: _____
	Records may be sent to your referring provider	*Records may be sent to your PCP*

Height: **Weight:** **Race:** **Ethnicity:** ☐ Hispanic ☐ Non-hispanic

Past Surgical History (*If none, please mark NONE*)

Select all previous hospitalizations/surgeries: ☐ **NONE**

		Orthopedic Surgery:	Right	Left
☐ Aneurysm (Brain) Surgery	☐ Hysterectomy	☐ Arthroscopy: Knee	☐	☐
☐ Aortic Bypass / Vascular Surgery	☐ LAP Band / Gastric Bypass Surgery	☐ Arthroscopy: Shoulder	☐	☐
☐ Appendectomy	☐ Lumpectomy	☐ Carpal Tunnel Release	☐	☐
☐ Cataract (Eye) Surgery	☐ Mastectomy	☐ Rotator Cuff Repair	☐	☐
☐ Cholecystectomy (Gallbladder)	☐ Malignancy / Cancer	☐ Total Hip Replacement	☐	☐
☐ Heart Surgery	☐ Stents	☐ Total Knee Replacement	☐	☐
☐ Hernia Repair	☐ Tonsillectomy	☐ Total Shoulder Replacement	☐	☐
☐ Other Surgery:				
☐ Spinal Surgery - Indicate Level:		☐ Other Orthopedic Surgery:		

Medical Questions

Mark all that currently apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Use a C PAP ☐ Snores

Are you taking blood thinners? (Aspirin, Xarelto, Coumadin, Ibuprofen, etc..) ☐ Yes ☐ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months (*If none, please mark NONE*)

☐ **None for all**

		NONE	COMMENTS
1) GI	☐ Heartburn, Ulcers ☐ Nausea, Vomiting ☐ Blood in Stool ☐ Stomach Pain	☐	
2) ENDO	☐ Fever ☐ Heat or Cold Intolerance ☐ Night Sweats ☐ Excessive Thirst	☐	
3) CON	☐ Weight Loss ☐ Loss of Appetite ☐ Fatigue	☐	
4) EYE	☐ Blurred Vision ☐ Double Vision ☐ Vision Loss ☐ Headaches	☐	
5) ENT	☐ Hearing Loss ☐ Hoarseness ☐ Trouble Swallowing	☐	
6) CARDIO	☐ Chest Pain ☐ Palpitations ☐ Faintness/Dizziness	☐	
7) LUNGS	☐ Chronic Cough ☐ Pneumonia ☐ Shortness of Breath ☐ Wheezing	☐	
8) GU	☐ Painful Urination ☐ Blood in Urine ☐ Kidney Problems	☐	
9) SKIN	☐ Frequent Rashes ☐ Skin Ulcers ☐ Lumps	☐	
10) NEURO	☐ Frequent Falls ☐ Loss of Coordination/Balance ☐ Change in Bowel ☐ Change in bladder ☐ Dizziness ☐ Numbness ☐ Seizures	☐	
11) PSYCH	☐ Depression/Anxiety ☐ Drug/Alcohol Addiction ☐ Sleep Disorder	☐	
12) HEM	☐ Easy Bleeding ☐ Easy Bruising ☐ Anemia	☐	

Are there any other joints with morning stiffness, swelling, or pain? ☐ Yes ☐ No

Family History	**Have any direct relatives had any of the following disorders?**				☐ **None for all**
Father	☐ None ☐ Rheumatoid Arthritis	☐ Diabetes ☐ Reaction to Anesthesia	☐ Heart Disease	☐ Hypertension Comments:	☐ Bleeding Problems
Mother	☐ None ☐ Rheumatoid Arthritis	☐ Diabetes ☐ Reaction to Anesthesia	☐ Heart Disease	☐ Hypertension Comments:	☐ Bleeding Problems
Sibling	☐ None ☐ Rheumatoid Arthritis	☐ Diabetes ☐ Reaction to Anesthesia	☐ Heart Disease	☐ Hypertension Comments:	☐ Bleeding Problems

Social History

Do you smoke tobacco?	☐ Daily	☐ Occasionally	☐ Former Smoker	☐ Never	☐ Unknown # packs/day: _____
Do you drink alcohol?	☐ Daily	☐ Occasionally	☐ Rarely	☐ Never	
Marital History	☐ Married	☐ Single	☐ Divorced	☐ Widowed	☐ Domestic Partnership
Are you currently working?	☐ Yes	☐ No	☐ Retired	☐ Disabled	
Occupation:		Employer:		☐ Student	

Personal Medical Information (*If none, please mark NONE*)

ALLERGIES? ☐ **Yes** ☐ **No**

☐ To Medication(s):

☐ To Food(s):

☐ Other(Latex, Seasonal, etc.):

CURRENT MEDICATION LIST: (list anything you take on a regular basis) **REASON FOR MEDICATION:** **OR** ☐ **None**

Do you have a personal history of any of the following? **OR** ☐ **None of the following**

☐ Aneurysm – Where? _____
☐ Angina (chest pain)
☐ Arthritis – Type:
☐ Asthma
☐ Bone or Joint Infections
☐ Cancer – Type: _____
☐ Chemotherapy/Radiation
☐ COPD
☐ Congestive Heart Failure
☐ Diabetes – Type:
Last A1C: _____
☐ Emphysema
☐ Epilepsy
☐ Heart Problems
☐ Hepatitis – Type: _____
☐ HIV/AIDS
☐ High Cholesterol
☐ Hypertension (High Blood Pressure)
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Other:
_____
☐ Kidney Disease
☐ Kidney Stones
☐ MRSA Infection
☐ Pacemaker
☐ Phlebitis (Blood Clots)
☐ Pulmonary Embolism
☐ Reaction to Anesthesia – Type:
_____
☐ Seizures
☐ Stomach Ulcers
☐ Stroke/TIA
☐ Tuberculosis