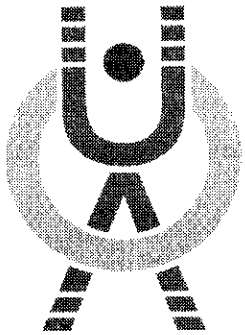

# URQUHART ORTHOPEDIC ASSOCIATES

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## PATIENT REGISTRATION FORM

Last Name:_____First Name_____

Address:_____

Date of Birth:_____ Social Security:_____

Home Phone:_____ Work :_____ Cell :_____

Sex: ___ M___ F Marital Status: __Single __Married __Divorced __Widow __Other

**********

Card Holder Name:_____ Social Security:_____

Date of Birth:_____ Home Phone:_____

**********

Retired? ___Yes ___No Occupation _____ Employer_____

Employer Address:

_____

**********

Primary Doctor Name:_____ Phone:_____

Primary Doctor Address:_____

Referring Doctor Name:_____Phone:_____

Referring Doctor Address:_____

**********

Person to contact in case of emergency _____

Relationship to Patient_____

**Is this person authorized to discuss your medical condition/obtain Health and/or Billing information with us? ___Yes ____No**

Home Phone:_____

Work Phone:_____

**If Patient is a Minor**

Parent/Legal Guardian:_____ Home Phone:_____

Address:_____

Parents Date of Birth:_____ Parents Social Security:_____

**I have received The Notice of Privacy Practices from Urquhart Orthopedic Associates on**

_____/_____/_____

**Signed**_____

**INSURANCE**

Primary Insurance Name & ID # :_____

Secondary Insurance Name & ID # :_____

***If work or auto accident, please also provide private insurance.***

____Work Related ____Automobile Related Date of Injury ___/___/_____

Insurance Company:_____ Adjuster name:_____

Insurance Address:_____ Adjuster phone:_____

_____ Adjuster fax:_____

**DESCRIPTION/HISTORY OF INJURY**

Reason for Visit:_____

Is your visit the result of an accident or injury? ___Yes ___No Date of Injury: _____

Was this a work related injury? ___Yes ___No Was this an auto accident? ___Yes ___No

Recreational or school athletic injury? ___Yes ___No

Other type of accident? ____ Yes ____No

Explain:_____

Were you hospitalized? ___Yes ___No

Did you go to Emergency Room? ___Yes ___No If yes, hospital name: _____

Date of treatment:_____ Were x-rays taken? ___ Yes ___No

Are you currently working? ___Yes ___No

If yes, are you working: ___Full Duty ___Light Duty

**HEALTH HISTORY**

Weight_____ Height_____ Are you or could you be pregnant? ___Yes ____No

Start of your last Menstrual Cycle___/___/_____ Onset of Menopause___/___/_____

ARE ALL IMMUNIZATIONS UP TO DATE? ____ YES ____NO IF NO, WHICH IMMUNIZATIONS ARE DUE?

_____

TETANUS _____YES _____NO DATE RECEIVED_____/_____/_____

**SURGERIES** (Please list all surgeries and dates of surgeries)

_____

_____

_____

_____

_____

| FAMILY HISTORY FAMILY MEMBER | ALIVE | DECEASED | AGE | HEALTH STATUS OR CAUSE OF DEATH |
|---|---|---|---|---|
| GRANDMOTHER (MOM) | _____ | _____ | _____ | _____ |
| GRANDFATHER (MOM) | _____ | _____ | _____ | _____ |
| GRANDMOTHER (DAD) | _____ | _____ | _____ | _____ |
| GRANDFATHER (DAD) | _____ | _____ | _____ | _____ |
| FATHER | _____ | _____ | _____ | _____ |
| MOTHER | _____ | _____ | _____ | _____ |
| SISTER/BROTHER | _____ | _____ | _____ | _____ |
| SISTER/BROTHER | _____ | _____ | _____ | _____ |
| SISTER/BROTHER | _____ | _____ | _____ | _____ |

**MEDICATIONS (Please list all medications including dosages)**

| MEDICATION | DOSAGE | REASON FOR MEDICATION | SIDE EFFECTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you take any of the following blood thinning medications on a daily basis?

___Aspirin ___Ibuprofen/Motrin ___Acetaminophen ___Fish Oil ___Coumadin ___ Plavix

___Other _____

**Allergies to any Medications, Latex or Food?** ___Yes ___No

Please list and include type of reaction for each. (Example Penicillin, nausea and vomiting)

_____

_____

_____

Do you smoke? ___Yes ___No Packs/day? ____ Years Smoked?____ Year Quit?____

Do you drink alcohol? ___Yes ___No If yes, how often?_____

Do you have a history of Substance abuse? ___Yes ___No If yes, please explain

_____

Do you use products containing caffeine? ___ Yes___ No

If yes, what type and how often?_____

Are you left or right handed? _____

**Are you currently having or have you had problems with your**

| | DESCRIBE ALL YES RESPONSES |
|---|---|
| **EYES** | ___YES___NO _____ |
| **DIABETES** | ___YES___NO _____ |
| **EARS, NOSE, THROAT** | ___YES___NO _____ |
| **LUNGS, BREATHING** | ___YES___NO _____ |
| **DIGESTION** | ___YES___NO _____ |
| **BOWEL** | ___YES___NO _____ |
| **BLADDER** | ___YES___NO _____ |
| **HEART CONDITION** | ___YES___NO_____ |
| **HIGH BLOOD PRESSURE** | ___YES___NO _____ |
| **BALANCE PROBLEMS** | ___YES___NO _____ |
| **NUMBNESS/TINGLING** | ___YES___NO _____ |
| **BLACKOUT/FAINTING** | ___YES___NO _____ |
| **PSYCHOLOGICAL PROBLEMS** | ___YES___NO _____ |
| **HIV/AIDS** | ___YES___NO _____ |
| **CANCER** | ___YES___NO _____ |
| **ARTHRITIS** | ___YES___NO _____ |
| **POLIO** | ___YES___NO _____ |
| **TB** | ___YES___NO _____ |
| **EPILEPSY** | ___YES___NO _____ |
| **GERD** | ___YES___NO _____ |
| **HEPATITIS** | ___YES___NO _____ |

## PATIENT CONFIDENTIALITY

In this office, patient confidentiality is a prime concern. Please indicate below with whom our office can or cannot leave a message/discuss your medical situation.

| | | | |
|---|---|---|---|
| Spouse | ___Yes___ No | Children | ___Yes___ No |
| Parent | ___Yes___ No | Answering Machine | ___Yes___ No |
| Are you able to receive calls at your work place? | | | ___Yes___ No |
| May we call you at your work place and state who is calling? | | | ___Yes___ No |

_____

Patient Signature

_____ _____

EXAMINING PHYSICIANS SIGNATURE DATE