



Today's Date: \_\_\_\_\_

www.PremierOrtho.com

Patient Registration Form

General Information

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Responsible Party \_\_\_\_\_ Parent SS# \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Number \_\_\_\_\_

Work Phone \_\_\_\_\_ Email address \_\_\_\_\_

Marital Status (circle one): Single Married Widowed Separated Divorced

Sex: Male Female Employment Status (circle one): Employed F/T Student P/T Student

Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Who referred you? \_\_\_\_\_

Family Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Do you want a report sent to your primary physician? Y N

Pharmacy Name \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Insurance Information

Type of Coverage (Circle One): Health Workers Comp Auto Accident Slip & Fall None/Self Pay

Primary Insurance \_\_\_\_\_

Claim/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Address/Zip \_\_\_\_\_ Phone \_\_\_\_\_

Adjustors Name \_\_\_\_\_ Adjustors Phone \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship Self Spouse Parent Other

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Responsibly party employer \_\_\_\_\_ Supervisor Name \_\_\_\_\_

Address \_\_\_\_\_

MEDICARE PATIENTS ONLY

Secondary Insurance \_\_\_\_\_

Claim/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Address/Zip \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship Self Spouse Parent Other

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_



Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

**Injury Information**

Main reason for today's visit \_\_\_\_\_

Who referred you? \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Date of Injury \_\_\_\_\_ Type of Injury (Circle One): Work Sports Auto Other

When did symptoms begin \_\_\_\_\_

Rate your pain on a scale of 1-10

1 2 3 4 5 6 7 8 9 10

Briefly describe symptoms

\_\_\_\_\_  
\_\_\_\_\_

Are these symptoms: New \_\_\_\_\_ Have had before \_\_\_\_\_ When? \_\_\_\_\_

Where/when first treated \_\_\_\_\_

List physicians who have treated you for this problem \_\_\_\_\_

\_\_\_\_\_

Have you had surgery for this problem? Y N

Describe \_\_\_\_\_

List Xrays, MRIs, scans or other special studies or blood work performed & which facility

\_\_\_\_\_  
\_\_\_\_\_

As a result of this problem has there been any changes in your employment? Y N

Not Employed \_\_\_\_\_ No Change in Duty \_\_\_\_\_

Unable to Work \_\_\_\_\_ Working Light Duty \_\_\_\_\_

**What are you hoping to achieve during this visit** \_\_\_\_\_

\_\_\_\_\_

**Social History**

**Family Medical History  
(Mother/Father)**

Smoke Y/N Occasional \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy \_\_\_\_\_

Alcohol Y/N Occasional \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy \_\_\_\_\_

Other Substances Y/N Occasional \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICAL HISTORY/SYSTEMS REVIEW

	Y	N		Y	N		Y	N
Fever	_____	_____	Ulcer/Gastritis	_____	_____	Phlebitis/Blood Clots	_____	_____
Weight Loss	_____	_____	Urinary Problems	_____	_____	Thyroid Problems	_____	_____
Eye Problems	_____	_____	Fractures/Disloc	_____	_____	High Blood Pressure	_____	_____
ENT Problems	_____	_____	Skin Rashes	_____	_____	Low Blood Pressure	_____	_____
Heart Problems	_____	_____	Nerve Problems	_____	_____	Tumor or Cancer	_____	_____
Breathing Problems	_____	_____	Anxiety/Depression	_____	_____	Gout	_____	_____
Seizures	_____	_____	Bone/Joint Problems	_____	_____	Liver Problems	_____	_____
Diabetes	_____	_____	Numbness	_____	_____	Kidney Problems	_____	_____
Blood Disorder	_____	_____	STDs	_____	_____	Are you Pregnant	_____	_____

If Yes, please describe \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List medications and vitamins you are taking \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List allergies \_\_\_\_\_  
 \_\_\_\_\_

What other medications have you tried for this condition \_\_\_\_\_

Previous surgeries (any type) \_\_\_\_\_  
 \_\_\_\_\_

**Authorization For Release of Information and Direct Payment to the Doctor**

**DIRECT PAYMENT:** I authorize and direct my Insurance Carrier(s) to make payments for medical or surgical treatment, injections, supplies and x-rays directly to Premier Orthopaedic & Sports Medicine Associates, Ltd. I hereby authorize the submission of all information necessary to complete this claim. These authorizations shall be effective for myself and my dependents. I agree that a copy of this authorization shall be as valid as the original.

**MEDICARE and MEDIGAP:** I request that payment of authorized MEDICARE AND MEDIGAP benefits be made either to me or on my behalf to the physician named below for services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents to my MEDIGAP insurer and any information needed to determine these benefits or the benefits payable for the related services.

*I understand and agree that I am responsible for payment of all charges not fully paid by my insurance*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent to Treat**

I authorize the Physicians and other medical providers of Premier Orthopaedics and Sports & Spine Rehabilitation to render treatment for my visits to this practice.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>For Office Use:</b>			
Height _____	Weight _____	Pulse _____	Respiration _____
Physician Signature _____		Date _____	