NEW PATIENT REGISTRATION FORM

Patient (Legal) Name: _____ Nickname: _____

SSN (>Age 18): _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Mailing Address: _____ (Street/PO Box)
_____ (City State Zip Code)

Home Address: _____ (Street)
_____ (City State Zip Code)

The Federal government now requires that we collect the following information:

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Multi-racial ☐ Other: _____
Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Student Status: ☐ Full-Time ☐ Part-Time ☐ N/A

Home Phone (1): _____ IN CASE OF EMERGENCY PLEASE CONTACT:

Cell (Day) Phone (2): _____ Name: _____

Work (Alt) Phone (3): _____ Relationship: _____

Email: _____ Phone #: _____

(1) Primary Insurance

Insurance Name: _____ Effective Date: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent Policy Holder Sex: ☐ Male ☐ Female

Policy ID #: _____ Group #: _____

(2) Secondary Insurance

Insurance Name: _____ Effective Date: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent Policy Holder Sex: ☐ Male ☐ Female

Policy ID #: _____ Group #: _____

For Minor Children Only: "Responsible Party" is the parent who completes this form

Responsible Party Name: _____ Home Phone: _____

SSN: _____ Date of Birth: _____ Cell Phone: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

ASSIGNMENT OF BENEFITS:
I verify that the information provided above is complete and correct. I request that payment of authorized insurance or Medicare benefits be made on my behalf to Cape Fear Orthopaedic Clinic, P.A. for any medical services or supplies furnished to me by that organization. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits.

Patient/Legal Guardian Signature: _____ Date: _____

Cape Fear Orthopedics

EXPERIENCE & INTEGRITY

HIPAA CONSENT & ACKNOWLEDGMENT

Patient Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

I have been given a copy of Cape Fear Orthopaedic Clinic, P.A.'s Notice of Privacy Practices, version effective September 1, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

**Signature of Patient or Representative: _____

( ) Self ( ) Parent ( ) Legal Guardian ( ) Representative under Health Care POA

Print Name: _____ Date: _____

RELEASE OF PHI TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care: ☐ None

Name: _____ Relationship: _____

Information to be released (check all that apply): ☐ All Medical ☐ Record Copies/Prescriptions ☐ Appointment(s) ☐ Billing

Name: _____ Relationship: _____

Information to be released (check all that apply): ☐ All Medical ☐ Record Copies/Prescriptions ☐ Appointment(s) ☐ Billing

My consent will remain in effect as long as I am a patient of Cape Fear Orthopaedic Clinic, P.A. unless and until I notify Cape Fear Orthopaedic Clinic, P.A. in writing of any changes.

**Signature of Patient or Representative: _____

( ) Self ( ) Parent ( ) Legal Guardian ( ) Representative under Health Care POA

Print Name: _____ Date: _____

FOR OFFICE USE ONLY

If an acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

Patient Name: _____ Date of Birth: _____

****PLEASE READ AND INITIAL EACH SECTION – SIGNATURE REQUIRED ON PAGE 2****

FINANCIAL POLICY

Patient Initials _____

We would like to thank you for choosing Cape Fear Orthopedics as your medical provider. Because we are committed to providing you with the best possible care and service, we would like to make you aware of our financial policy. We require that you read and initial this document prior to receiving medical treatment.

- **Co-payments, Deductibles, and Fees:** Co-payments, deductibles and fees for services not covered by your insurance are due at the time service is rendered. We accept cash, checks, and most major credit cards. A $25.00 fee will be assessed to your account if a check is returned for non-sufficient funds.
- **Insurance:** You must present a current insurance card at each visit. If your insurance plan is not one we participate with, we will assist in filing your insurance claim, but payment in full is expected at the time of service. It is your responsibility to provide timely and accurate information to our office so claims can be properly submitted.
- **Minors and Dependants:** Our practice will bill the insurance for both parents (if applicable). The parent that accompanies the child to his or her first appointment will be considered financially responsible for payment, regardless of the subscriber (parent) listed on the child's insurance card. We do not get involved in child custody issues.
- **Auto Insurance/Third Party Liability:** Please notify our office immediately if your injury is a result of an auto accident or third party liability. While we do not general accept third party liability, there are exceptions if you have Medicare or Medicaid. You may be responsible for payment at the time of service if your treatment is related to third party liability.
- **Missed Appointments:** Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from the practice.
- **Prompt Payment:** We expect that you will make every effort to pay your bill promptly. If you do not have medical insurance, have a financial hardship, or if you are unable to pay your bill in its entirety please contact our billing office prior to your appointment to discuss payment options. Chronic non-payment will be grounds for dismissal from the practice. We reserve the right to turn any account over to a collection agency if the account is not paid within 30 days.

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by Cape Fear Orthopaedic Clinic, P.A. I understand that I am financially responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of co-pays and any prior balance I may owe is due at the time of service unless a payment agreement is on file. I hereby request that payment of insurance or Medicare benefits be made on my behalf to Cape Fear Orthopaedic Clinic, P.A. for any medical services or supplies furnished to me by that organization.

CONSENT TO TREATMENT

Patient Initials _____

I am a new or current patient at Cape Fear Orthopaedic Clinic, P.A. By signing this form, I consent to be treated by the providers of this practice. My medical provider needs more medical facts about my health. I ask for and allow the medical providers and staff to give me the needed medical treatment and services recommended by my physician or physician assistant. I understand that treatment and services may include, but is not limited to the following:

● routine exams ● diagnostic tests ● casts/splints ● injections ● lab tests ● x-rays ● screening tests

I understand that no promises have been made to me about the results of any treatment or services.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

Patient Initials _____

By signing below I give permission, without limitation or exclusion, for Cape Fear Orthopaedic Clinic, P.A. and it's providers to view my external prescription history via Surescripts for purposes of my care and treatment. I understand that my medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

I certify that I read and understand the scope of my consent and that I authorize access.

PRESCRIPTION REFILL and PAIN MEDICATION POLICY **Patient Initials** _____

Prescription Refills:

1. Only one pharmacy may be used for filling prescriptions. You should notify us if you change pharmacies.
2. Because most physicians are only in clinic 2-3 days per week, prescription refills may take 3-5 business days to process. Please do not wait until you run out of medication to request a refill.
3. Take your medication exactly as instructed by your provider. Never change the dosage or frequency of your medication without instructions from your physician. Refill requests will **not** be approved if you "run out early".
4. You may request a refill during our normal business hours. Requests for refills will **not** be accepted after hours.
5. You are responsible for keeping your prescriptions and medications safely in your care. Lost or stolen medications or prescriptions will **not** be replaced until it is time for your next refill. Exceptions may be made if you have a police report, but only at the discretion of your doctor.
6. You may be required to see your physician for a follow-up visit prior to obtaining a medication refill.

Pain Medications:

If you have a medical condition requiring pain control, your medical provider may recommend that you take a narcotic (pain-killer) drug. These drugs should lower or take away your pain. There are some important things you should know about narcotic (pain-killer) drugs before you agree to take them:

- Pain-killer drugs may have major side effects and risks. Medication should be taken only as directed.
- Narcotic use is under the control of many regulatory agencies. Doctors must follow local, state, and federal laws when prescribing these drugs.

Risks and common problems include:

1. **Addiction** – You could become mentally and physically dependent on them. Your doctors may order extra blood, urine, or hair testing and may refer you to an addiction specialist if there is a worry about addiction.
2. **Side effects** – Include a feeling of sickness to your stomach, trouble having a bowel movement, sweating, and itchiness of the skin. You may also feel sleepy.
3. **Pregnancy** – Do **not** get pregnant while you are taking pain-killers. These drugs could result in harm to your baby or loss of the pregnancy (miscarriage).
4. **Alcohol or illegal drugs** – Do **not** use alcohol or illegal drugs while taking pain-killers. This mixture could cause death.
5. **Heavy or dangerous machinery** – Do **not** use heavy or dangerous machinery, handle guns, or use other weapons while taking pain-killers.
6. **Driving** – Driving while on a pain-killer drug is **not** recommended. Pain-killers can change your driving skills.

By signing below you agree that you have read this document and understand the clinic's policy regarding prescriptions and the rules for taking narcotic (pain-killer) drugs:

1. It is against the law to make any changes to a prescription after it is written. If you change a prescription, it will be reported to the police and no more drugs will be given to you.
2. Getting pain-killer drugs from more than one doctor at a time is not allowed. This is against the law and may be considered a felony. You have a duty to let other doctors know if you are taking narcotic (pain-killer) drugs.
3. From time-to-time, our staff may talk to the pharmacist or access the NC Controlled Substance Reporting System to check your full prescription profile.
4. Prescriptions should only be picked up by you. If you are unable to pick up your prescriptions, we will only release your prescription to authorized persons as listed on your HIPAA Consent Form. Our office does require that you show a photo ID when picking up prescriptions.
5. I agree to comply with random urine, blood, or breathe testing to document the proper use of pain medication, as well as confirming compliance. I understand that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

****Signature of Patient or Representative**: _____

( ) Self ( ) Parent ( ) Legal Guardian ( ) Representative under Health Care POA

****Signature of Witness**: _____

Date: _____ Time: _____ am/pm

(Office Use Only) Person#: _____

PEDIATRIC MEDICAL HISTORY FORM

Patient Legal Name: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female Height _____ Weight _____

Referring Physician: _____ Primary Care Physician: _____

Reason for today's visit: _____ When did this injury/problem occur? _____

HEALTH HISTORY OF PATIENT

Immunizations up-to-date ---------- □ Yes □ No
Seizures ---------- □ Yes □ No
Arthritis ---------- □ Yes □ No
Anemia ---------- □ Yes □ No
Asthma ---------- □ Yes □ No
Thyroid disease ---------- □ Yes □ No
Delay in development ---------- □ Yes □ No
Mental illness ---------- □ Yes □ No
Cancer ---------- □ Yes □ No
Heart trouble ---------- □ Yes □ No
Stomach trouble ---------- □ Yes □ No
Other illness ---------- □ Yes □ No
Difficulty walking ---------- □ Yes □ No
Serious injuries ---------- □ Yes □ No
Bleeding disorders ---------- □ Yes □ No
Lung Disease ---------- □ Yes □ No
Kidney/bladder trouble ---------- □ Yes □ No

Explain all "yes" answers: _____

_____

List ALL operations and approximate date: _____ _____

Current medications and dosage: _____ _____

List ALLERGIES to medications------- ☐ NONE _____ _____

FAMILY HISTORY

Heart problems ---------- □ Yes □ No
Seizures ---------- □ Yes □ No
Bleeding disorders ---------- □ Yes □ No
Diabetes ---------- □ Yes □ No
Mental illness ---------- □ Yes □ No
Other ---------- □ Yes □ No
Arthritis ---------- □ Yes □ No
Kidney/Bladder trouble ---------- □ Yes □ No

Explain all "yes" answers: _____

_____

SOCIAL HISTORY

Number of people living in child's home _____

How many are adults (number and relationship) _____

How many are brothers (number and ages) _____

How many are sisters (number and ages) _____

Other's (number and ages) _____

Grade in school _____

Smoke_____ packs per day

Alcohol use ---------- □ None □ Occasional

Illicit Drug use ---------- □ None □ Presently □ Past

DEVELOPMENTAL HISTORY (if child is younger than 2 years of age)

Roll over back to front ---------- □ Yes □ No
Pull to a stand ---------- □ Yes □ No
Sit with support ---------- □ Yes □ No
Walk independently ---------- □ Yes □ No
Crawl ---------- □ Yes □ No
Run ---------- □ Yes □ No

DEVELOPMENTAL HISTORY (if child is 2 to 6 years of age)

Stairs, one leg at a time ---------- □ Yes □ No
Hops on one foot ---------- □ Yes □ No
Stairs, alternating legs ---------- □ Yes □ No
Skips ---------- □ Yes □ No
Jumps ---------- □ Yes □ No

REVIEW OF SYSTEMS (Present NOW or Past 2 months)

Chills or fever ---------- □ Yes □ No
Frequent headaches ---------- □ Yes □ No
Change in vision ---------- □ Yes □ No
Ear pain ---------- □ Yes □ No
Sore throat ---------- □ Yes □ No
Heart or chest pain ---------- □ Yes □ No
Nausea or vomiting ---------- □ Yes □ No
Frequent loose bowel movements □ Yes □ No
Frequent rash ---------- □ Yes □ No
Unusual weight change ---------- □ Yes □ No
Exhaustion ---------- □ Yes □ No
Reading glasses ---------- □ Yes □ No
Frequent nosebleeds ---------- □ Yes □ No
Difficulty swallowing ---------- □ Yes □ No
Poor appetite---------- □ Yes □ No
Stomach pain ---------- □ Yes □ No
Frequent urination (passing water) □ Yes □ No
Hot or cold spells ---------- □ Yes □ No
Seizures ---------- □ Yes □ No
Depression ---------- □ Yes □ No
Loss of hearing ---------- □ Yes □ No
Hoarseness ---------- □ Yes □ No
Shortness of breath ---------- □ Yes □ No
Toothache/gum trouble ---------- □ Yes □ No
Frequent constipation ---------- □ Yes □ No
Burning sensation during urination -- □ Yes □ No

Form Completed by _____ Date_____

( ) Parent ( ) Legal Guardian

Reviewed by_____MD/PA-C Date_____