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): ______________________

Cell (Day) Phone (2): ______________________

Work (Alt) Phone (3): ______________________

Email: ______________________

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: ______________________

Relationship: ______________________

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: ____________

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#: ___________________________________

MEDICAL HISTORY FORM

Patient Legal Name: ______________________________ Date of Birth: ______________

Primary Care Physician: ______________________ Referring Provider: ______________________

PLEASE LIST EACH INJURY/PROBLEM (Body Part) SEPARATELY

(1) Reason for today's visit: ______________________ Rate your pain from 1-10 (10 = worst): ________

Injury Date (if applicable): ______________ **Injury Type**: ☐ work ☐ sports ☐ home ☐ auto accident ☐ third party ☐ other

If no injury, when did this problem begin? ______________________

Please describe how the injury/problem began: ______________________

Since this began, is your pain: ☐ better ☐ worse ☐ unchanged

Describe Symptoms/Pain: ☐ intermittent ☐ occasional ☐ constant ☐ rare ☐ aching ☐ burning ☐ dull ☐ piercing ☐ sharp ☐ throbbing

Symptoms Aggravated by: ☐ standing ☐ walking ☐ lifting ☐ squatting ☐ kneeling ☐ bending ☐ pushing ☐ other: ____________

Symptoms Relieved by: ☐ rest ☐ ice ☐ elevation ☐ OTC medicine ☐ injection ☐ physical therapy ☐ nothing ☐ other: ____________

Other Symptoms: ☐ bruising ☐ crepitus ☐ decreased mobility ☐ difficulty sleeping ☐ fever ☐ locking ☐ pain ☐ swelling ☐ joint stiffness ☐ tenderness ☐ limping ☐ muscle stiffness ☐ numbness ☐ popping ☐ tingling ☐ weakness

(2) Reason for today's visit: ______________________ Rate your pain from 1-10 (10 = worst): ________

Injury Date (if applicable): ______________ **Injury Type**: ☐ work ☐ sports ☐ home ☐ auto accident ☐ third party ☐ other

If no injury, when did this problem begin? ______________________

Please describe how the injury/problem began: ______________________

Since this began, is your pain: ☐ better ☐ worse ☐ unchanged

Describe Symptoms/Pain: ☐ intermittent ☐ occasional ☐ constant ☐ rare ☐ aching ☐ burning ☐ dull ☐ piercing ☐ sharp ☐ throbbing

Symptoms Aggravated by: ☐ standing ☐ walking ☐ lifting ☐ squatting ☐ kneeling ☐ bending ☐ pushing ☐ other: ____________

Symptoms Relieved by: ☐ rest ☐ ice ☐ elevation ☐ OTC medicine ☐ injection ☐ physical therapy ☐ nothing ☐ other: ____________

Other Symptoms: ☐ bruising ☐ crepitus ☐ decreased mobility ☐ difficulty sleeping ☐ fever ☐ locking ☐ pain ☐ swelling ☐ joint stiffness ☐ tenderness ☐ limping ☐ muscle stiffness ☐ numbness ☐ popping ☐ tingling ☐ weakness

DRUG ALLERGIES: **Please list any medication that you are allergic to.

☐ I have **NO KNOWN DRUG ALLERGIES**
☐ I am allergic to **LATEX**

Drug/Type of Reaction:

______________________ ______________________

______________________ ______________________

MEDICATION LIST: **Please list all over the counter and prescription medications that you are currently taking (including vitamins and herbal supplements).

Medication/Dosage/Frequency: ☐ **I DO NOT** currently take any medications including vitamins or herbal supplements

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Preferred Pharmacy: ______________________ Phone: ______________

****IF YOU HAVE ALREADY ENTERED YOUR MEDICAL HISTORY INFORMATION THROUGH THE PATIENT PORTAL IT IS NOT NECESSARY FOR YOU TO COMPLETE THIS SIDE OF THE FORM****

Past Medical History: **No Previous Medical Problems**

AIDS/HIV	Congestive heart failure	GERD	Migraine headaches	Renal disease
Alcoholism	COPD	Gout	Multiple sclerosis	Rheumatoid arthritis
Alzheimer's	Coronary artery disease	Hepatitis	Myocardial infarction	Scoliosis
Anemia	Crohn's disease	Hyperlipidemia	Obesity	Seizure disorder
Angina	Degenerative joint disease	Hypertension	Osteoarthritis	Sleep Apnea
Arthritis	Depression	Inflammatory bowel disease	Osteoporosis	SLE
Asthma	Diabetes	Juvenile rheumatoid arthritis	Parkinson's disease	Spinal stenosis
Atrial fibrillation	Drug abuse	Kidney disease	Peptic ulcer disease	Spondyloarthopathy
BPH	DVT	Liver disease	Psoriasis	Thyroid disease
Cancer	Fibromyalgia	Lyme disease	PVD	Valvular disease
CVA (stroke)	Gallbladder disease			Other: _______________

Past Surgical History: Please indicate the year you had surgery if applicable **No Previous Surgeries**

ACL Surgery: ______	Back surgery: _____	Hernia repair: _____	Rotator cuff repair: _____
Angioplasty: _____	CABG: _____	Hip Arthroplasty: _____	Small bowel resection: _____
Angio w/stent: _____	Cardiac valve replacement: _____	Hip Replacement: _____	Thyroidectomy: _____
Appendectomy: _____	Carpal tunnel release: _____	Knee Replacement: _____	Tonsillectomy: _____
Arthroscopy ankle: _____	Cataract extraction: _____	Laminectomy: _____	Other: ____________________
Arthroscopy elbow: _____	Cholecystectomy (Gallbladder): _____	LASIK: _____	
Arthroscopy hip: _____	Colectomy: _____	Meniscus surgery: _____	Gender Specific:
Arthroscopy knee: _____	Colostomy: _____	Muscle biopsy: _____	C-Section: _____
Arthroscopy wrist: _____	Discectomy: _____	ORIF: _____	Hysterectomy: _____
Arthroscopy shoulder: _____	Gastric bypass: _____	Pacemaker: _____	Mastectomy: _____

Family History:

Alcoholism	Congestive heart failure	Gout	Osteoarthritis
Alzheimer's disease	COPD	Heart disease	Osteoporosis
Anemia	CVA (stroke)	Hypertension	Parkinson's disease
Asthma	Diabetes	Kidney disease	Renal disease
Blood disease	Drug abuse	Liver disease	Seizure disorder
Cancer: Bone		Muscle disease	Thyroid disorder
Cancer: ________________________________		Obesity	Other: ______________________________

Social History:

Language Spoken: English Spanish Other: ____________________ Hand Dominance: right left ambidextrous

Current Work Status: full-time part-time self employed unemployed disabled retired

Employer Name: ____ Occupation: ________________________________

Marital Status: single married divorced widowed life partner How many children do you have? _______________

Who do you live with? live alone spouse parents mother father other: ____________________________________

Tobacco Use: Current / Former / Never Type: cigarettes cigar pipe chewing How much per day: _______ # Years: ____
Year Quit: ____________

Alcohol Use: No Yes: daily weekly socially rarely How Much? _____________

Illicit Drug Use: No Yes Formerly Age Started: ______ Years

Drug Type: _________________________________ Frequency: ___________ Route: ______________________

****Signature of Patient or Representative:** ____
( ) Self ( ) Parent ( ) Legal Guardian ( ) Representative under Health Care POA

Date: _______________________

☐ Verbal Information – Patient Unable to Complete Form Staff Initials: _________________