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: _____

FINANCIAL POLICY

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 sign this document prior to receiving medical treatment.

Co-payments, Deductibles, and Fees: Your insurance carrier requires that we collect your co-pay at the time of service. Deductibles and fees for services not covered by your insurance are also 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 you or your children do not present a current insurance card, you will be responsible for payment in full at the time of service. Your medical insurance is a contract between you and your insurance company. We will assist in filing your insurance claim, but you are primarily responsible for any charges incurred while you are a patient. If your insurance carrier is not one that we participate with, you are responsible for payment in full at the time of service. You have a responsibility to provide timely information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 60 days, because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment. If your insurance company pays the claim at a later date, your account will be credited and a refund may be issued.

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: In most cases we DO NOT accept auto insurance or other third party liability insurance. Exceptions do apply if you are currently insured under the Medicare or Medicaid program. If you are being seen for an injury due to an automobile accident or third party liability, please be sure to notify our office immediately. If your injury is a result of an auto accident or third party liability and you are not covered by Medicare or Medicaid, you will be responsible for paying in full at the time of service.

Missed Appointments: We may charge a $25.00 "no show" fee if you fail to keep a scheduled appointment or fail to cancel an appointment with at least 24 hours notice. This fee is not covered by your insurance plan and is your responsibility. Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from the practice.

Prompt Payment: Just as we make every effort to accommodate you when you are in need of medical care, 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. If you have a past due balance on your account, you may be required to reschedule your appointment. 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.

Patient Name: _____ Date of Birth: _____

Patient/Legal Guardian Signature: _____

(Office Use Only) Person#: _____

Cape Fear Orthopedics

EXPERIENCE & INTEGRITY

CONSENT TO TREATMENT

Patient Name: _____ Date of Birth: _____
(Please Print Clearly)

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.

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

Date: _____ Time: _____ am/pm

**Signature of Witness: _____

Date: _____ Time: _____ am/pm

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:

_____

_____

_____

PRESCRIPTION REFILL AND PAIN MEDICATION POLICY

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 dependant 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.

Patient Name: _____ Date of Birth: _____

Pharmacy Name and Location: _____

Patient/Legal Guardian Signature: _____ Date: _____

(Office Use Only) Person#: _____

Cape Fear Orthopedics

EXPERIENCE & INTEGRITY

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

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.

**Signature of Patient or Representative: _____

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

Date: _____ Time: _____ am/pm

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): _____

Location (body part): Right: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot/Toe ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand/Finger
Left: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot/Toe ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand/Finger
Other: _____

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): _____

Location (body part): Right: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot/Toe ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand/Finger
Left: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot/Toe ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand/Finger
Other: _____

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 medications that you are currently taking. ☐ NONE

Medication/Dosage/Frequency: Medication/Dosage/Frequency:

_____ _____

_____ _____

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

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

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

Gender Specific:
☐ C-Section: _____
☐ Hysterectomy: _____
☐ Mastectomy: _____

Family History:

☐ Alcoholism
☐ Alzheimer's disease
☐ Anemia
☐ Asthma
☐ Blood disease
☐ Cancer: Bone
☐ Cancer: _____
☐ Congestive heart failure
☐ COPD
☐ CVA (stroke)
☐ Diabetes
☐ Drug abuse
☐ Gout
☐ Heart disease
☐ Hypertension
☐ Kidney disease
☐ Liver disease
☐ Muscle disease
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's disease
☐ Renal disease
☐ Seizure disorder
☐ Thyroid disorder
☐ 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 Year Quit: _____ How much per day: _____ # Years: ____

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: _____