NEW PATIENT REGISTRATION FORM

Patient (Legal) Name: _____ **Nickname:** _____

Date of Birth: _____ ☐ **Male** ☐ **Female** ☐ **Other**

Home Address: _____
Street City State Zip Code

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

Home Phone: _____

Cell (Day) Phone: _____

Work (Alt) Phone: _____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

Email Address: _____

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

Are you right of left hand dominant? _____

The Federal Government requires that we collect the following information

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

Ethnicity: ☐ **Hispanic** ☐ **Non-Hispanic**

INSURANCE INFORMATION

PRIMARY

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 #:** _____

SECONDARY

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 COMPLETE THIS FORM

Responsible Party Name: _____ **Home Phone:** _____

SSN: _____ **Date of Birth:** _____ **Cell 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 that may 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 benefits.

Patient / Legal Guardian Signature: _____ **Date:** _____

HIPAA CONSENT & ACKNOWLEDGEMENT

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** ☐ **Caregiver**

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. Signing this form is optional. It is not required to receive treatment, and does not expire until you end it in writing.

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 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** ☐ **Caregiver**

Print Name: _____ **Date:** _____

FOR OFFICE USE ONLY

If an acknowledgement 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.

_____

_____

_____

MEDICAL HISTORY FORM

Patient (Legal) Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Referring Provider:** _____

PLEASE DESCRIBE YOUR INJURY / PROBLEM

Reason for today's visit: _____ ☐ Left ☐ Right ☐ Bi-Lateral

Injury Date: (if applicable) _____ **Rate your pain from 1-10 (10 being worst):** _____

Injury type: ☐ Work ☐ Sports ☐ Home ☐ Auto accident ☐ Other

If no injury, WHEN did this problem begin? _____ **HOW the injury/problem began:** _____

Any falls within the last 6 months? YES or NO **If yes, how many?** _____ **Did it result in an injury? YES or NO**

PLEASE MARK AT LEAST ONE PER CATEGORY

Since this began, is your pain:	☐ Better ☐ Worse ☐ Unchanged
Describe symptoms/pain:	☐ Intermittent ☐ Constant ☐ Aching ☐ Dull ☐ Throbbing ☐ Occasional ☐ Rare ☐ Burning ☐ Sharp
Symptoms aggravated by:	☐ Standing ☐ Lifting ☐ Kneeling ☐ Pushing ☐ Walking ☐ Squatting ☐ Bending ☐ Other: _____
Symptoms relieved by:	☐ Rest ☐ Injection ☐ OTC Medicine ☐ Nothing ☐ Elevation ☐ Ice ☐ Physical Therapy ☐ Other: _____
Associated Symptoms:	☐ Bruising ☐ Swelling ☐ Decreased Mobility ☐ Weakness ☐ Crepitus ☐ Tenderness ☐ Difficulty Sleeping ☐ Locking ☐ Limping ☐ Joint Stiffness ☐ Pain ☐ Numbness ☐ Muscle Stiffness ☐ Fever ☐ Popping ☐ Tingling

MEDICATION LIST - Please list all over the counter & prescription medications that you're currently taking

***Including vitamins & herbal supplements**

☐ I **DO NOT** currently take any medications including vitamins and herbal supplements

Pharmacy: _____

Phone: _____

Medication / Dosage / Frequency

_____ _____

_____ _____

_____ _____

_____ _____

OFFICE USE ONLY: **HT:** _____ **WT:** _____ **BP/Pulse:** _____

DRUG ALLERGIES - Please list medications that you are allergic to

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

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY - Please mark ALL that apply

☐ **No previous medical problems**

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cancer
- ☐ CVA (Stroke)
- ☐ COPD
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ DVT
- ☐ Fibromyalgia
- ☐ Gallbladder disease
- ☐ GERD
- ☐ Gout
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Inflammatory bowel disease
- ☐ Juvenile rheumatoid arthritis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lyme disease
- ☐ Multiple Sclerosis
- ☐ Myocardial infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peptic ulcer disease
- ☐ Psoriasis
- ☐ PVD
- ☐ Renal disease
- ☐ Rheumatoid arthritis
- ☐ Scoliosis
- ☐ SLE
- ☐ Spinal Stenosis
- ☐ Spondyloarthopathy
- ☐ Thyroid disease
- ☐ Valvular disease
- ☐ Other: _____

PAST SURGICAL HISTORY - Please mark ALL that apply and indicate the year you had the surgery

☐ **Not applicable**

- ACL Surgery_____
- Angioplasty _____
- Angio w/ stent_____
- Arthroscopy ankle _____
- Arthroscopy elbow _____
- Arthroscopy hip _____
- Arthroscopy knee _____
- Arthroscopy wrist _____
- Arthroscopy shoulder _____
- Back surgery _____
- C-Section_____
- CABG_____
- Cardiac valve replacement _____
- Carpal tunnel release _____
- Discectomy _____
- Gastric bypass _____
- Hip arthroplasty _____
- Hysterectomy _____
- Knee Replacement _____
- Laminectomy _____
- Meniscus surgery_____
- Muscle biopsy _____
- ORIF_____
- Pacemaker _____
- Rotator cuff repair _____
- Thyroidectomy _____
- Vasectomy: _____
- Other: _____

FAMILY HISTORY - Please mark ALL that apply

☐ **Not applicable**

- ☐ 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: _____

ALCOHOL AND DRUG USE:

Alcohol Use: ☐ No ☐ Yes **If yes, please circle:** daily weekly socially rarely **If yes, how much:** _____

Illicit Drug Use: ☐ No ☐ Yes ☐ Formerly **Age started:** _____ **Type / Frequency / Route:** _____

Tobacco Use: ☐ Current ☐ Former ☐ Never **How much per day:** _____ **# of Years:** _____

Please circle the type: cigarettes cigar pipe chewing **Year quit:** _____

Signature of Patient or Representative: _____

Date: _____ ☐ Self ☐ Parent ☐ Legal Guardian ☐ Representative under Health Care POA ☐ Caregiver

☐ **Verbal Information - Patient unable to complete form** **Staff Initials:** _____

Patient Name: _____ **Date:** _____

PLEASE READ AND INITIAL EACH SECTION - SIGNATURE REQUIRED ON PAGE 6

FINANCIAL POLICY

Patient Initials: _____

We would like to thank you for choosing Cape Fear Orthopaedics, P.A. 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 Dependents:** 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 generally 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 bills 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 Cape Fear Orthopaedic, 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 test

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

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. Request 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 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 doctor(s) may order extra blood, urine, or hair testing and may refer you to an addiction specialist if there is 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 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 requires that you show a photo ID when picking up prescriptions.
5. I agree to comply with random urine, blood, or breath 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 prescribed medications.

Signature of Patient or Representative: _____

☐ **Self** ☐ **Parent** ☐ **Legal Guardian** ☐ **Representative under Health Care POA** ☐ **Caregiver**

Signature of Witness: _____

Date: _____ **Time:** _____ **(Office Use Only) Person #** _____