Patient Registration Form

Patient's Name (Last, First, MI) ______________________________

Date of Birth ____ / ____ / ____ Social Security ______________________

Gender ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W

Do you have an advanced directive (Living will, health care proxy, DNR, power of attorney, etc)? ☐ Yes ☐ No

Home Address ______________________________

City ____________________ State __________ Zip ______________

Home Phone ______________ Cell Phone ____________ Work Phone ______________

Emergency Contact ______________ Relation ______________ Phone __________

Primary Care Physician ____________________ PCP Phone #: ______________

Referring Physician ____________________ Ref Phone #: ______________

Patient's Email ____________________ OK to leave message at home? ☐ Yes ☐ No

Race ______________ Ethnicity ______________ Primary Language ______________

Pharmacy ____________ Cross streets ______________ Phone ______________

Primary Insurance Company ______________________________

Policy Holder ____________________ Date of Birth _____ / _____ / _____

ID/Policy # ______________ Group # ______________ Co-Pay __________

Secondary Insurance Company ______________________________

Policy Holder ____________________ Date of Birth _____ / _____ / _____

ID/Policy # ______________ Group # ______________ Co-Pay __________

ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL INFORMATION

By signing my name below, I authorize the release of medical information necessary for filing health insurance claims and/or treatment for me by Desert Orthopedic Specialists, PC. I also authorize my insurance carriers to make payments directly to Desert Orthopedic Specialists, PC. **I understand that I am responsible for all charges not covered by my insurance.**

______________________________ ______________________________
Signature of the Patient or the Patient's Legal Representative Relationship to Legal Representative

______________________________ ______________________________
Print Name Date

PRACTICE CONSENTS FORM
3 Pages Total

Authorization for Release of Health Information to Family, Friends, and Caretakers:
Our office will not communicate your PHI to any other entity not listed on this form. If you have adult children, extended family members, caretakers, or other persons whom you want us to be able to speak to on your behalf regarding treatment, clinical, and administrative functions in our office you will need to list the person(s) below.

☐ **I hereby authorize Desert Orthopedic Specialists and its Employees permission to discuss, send, and/or receive my personal health information to/with the following individual(s):**

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

☐ **I do not wish any other entity or person other than myself to be able to discuss my care or treatment with this office. (Signature is still required)**

****Signature:** ____ Date: ______________________

Authorization for Prescription Information Usage:

I hereby authorize Desert Orthopedic Specialists to release any prescription information to pharmacies as needed. I also understand that Desert Orthopedic Specialists may use electronic databases to verify prior prescription history from other providers before one of our providers prescribes. We will not prescribe narcotics to any patients currently under contract with a pain management specialist. I understand that medication refills may not be possible after business hours.

****Signature:** ____ Date: ______________________

Acceptance of Patient Portal Authorization:

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an internet connection. Using a secure username and password, patients can communicate with our office to exchange secure e-mail with our healthcare team, request a prescription refill, and update contact information.

☐ By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions outlined in the Patient Portal Authorization Policy.

Your Email Address:

☐ I am declining the activation of my Patient Portal Account. (Signature is still required)

****Signature:** ____ Date: ______________

PRACTICE CONSENTS FORM
3 Pages Total

Consent for Text and Telephone Automated Messages

☐ By checking this box and clicking signing below, you agree that we may call or text you at the number you have provided us with for reminders, offers, and other clinically relevant info, including **APPOINTMENT REMINDERS**, automated technology health reminders to make future appointments, text and recorded messages from our staff.

You are not required to sign the agreement (directly or indirectly) or agree to enter into such an agreement as a condition of purchasing any property, goods, or services.

☐ If you do not consent, please check this box and sign below. Please note by doing this our system will not be able to send any digital reminders, nor will our staff be able to communicate with you by any means other than telephone via a live representative, or standard mail, which may delay your care in our office.

** Signature: ____ Date: ________________

Notice of Privacy Practices for Desert Orthopedic Specialists

☐ I am requesting a paper copy of the Desert Orthopedic Specialists' Privacy Policy explaining my rights regarding my individually identifiable health information (IIHI).

☐ I have declined a copy of the Privacy Notice explaining my rights regarding my individually identifiable health information (IIHI). I understand a copy of the Desert Orthopedic Specialists HIPPA policy is available on demand on the website www.DesertOrthoAZ.com at any time I should elect. Desert Orthopedic Specialists will only share my IIHI with other entities involved in providing treatment-related activities.

By signing below, I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment, or other healthcare operations related to my treatment plan. Other uses of my IIHI will require authorization from me for the specific intention of disclosure. My signature indicates I understand my rights about privacy and coordinating care with other entities.

****Signature:** ____Date: ______________________

Notice of Financial Policies for Desert Orthopedic Specialists

It is the "Provider's" Responsibility:

To provide quality medical care. Our team at Desert Orthopedic Specialists is committed to providing our patients with the highest quality care with surgical and non-surgical orthopedic treatment options as well as Alternative Health treatment options.

To file insurance claims. Desert Orthopedic Specialists, PC will file a claim with primary and, as a courtesy to our patients, secondary carriers only. All services rendered due to a work related injury will be billed to the appropriate worker's compensation plan so long as the claim and billing information is received by our office in advance.

It is the "Patient's" Responsibility:

To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance and copays. If you are not familiar with your plan coverage, we recommend you contact your carrier directly. (continued on next page)

PRACTICE CONSENTS FORM
3 Pages Total

To pay their patient responsibility amounts at the time of service. Please help us continue to keep patient care our first priority by promptly paying your patient responsibility amounts (copays, deductibles, cost shares, coinsurance amounts, etc.) at the time of service or prior to your upcoming service (i.e. surgery). This arrangement is part of your contract with your insurance company. Failure on our part to collect copays (and other patient responsibility amounts) can result in our being held in violation of our insurance contracts therefore our office will not waive any deductible, copay or coinsurance amounts.

To be an advocate in assisting our office with claims payment by contacting your insurance carrier when claims have not been paid within a reasonable time frame OR when you are asked to assist us.

Additional Practice-Related Fees That May Apply:

Co-Pays and Co-Insurance: Please pay these at the time of service. Late payments will result in a $10.00 administrative fee

Nonsufficient Funds: Non-sufficient funds will result in an additional $35 administrative fee.

Unpaid balances: A late charge of 1.5% per month (or 18% per annum) on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment. An additional Collection Fee of 50% will be added to your account balance if your account is transferred to collections for non-payment.

Missed Appointments and 'No Shows': Please cancel your appointment at least 24 hours in advance of your appointment. Less than 24 hour notice will cause a cancellation fee of $75.00.

Requests to complete LIFE, DISABILITY, FMLA and other forms: There is a $75.00 fee for each form.

Release of Medical Records: Our office is able to provide your other medical providers with a copy of your Desert Orthopedic Specialists records free of charge. However, records requested for any other entity will be assessed an administrative fee of $35 which is to be paid in advance of the records being released.

FINANCIAL POLICY ACKNOWLEDGEMENT

By signing my name below, I acknowledge that I have read and understand the Financial Policy of Desert Orthopedic Specialists, and I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I agree that if my account is referred to a collection agency or attorney, I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

****Signature:** ____ Date: _____________________

PATIENT HISTORY FORM

Name______________________________Age_____Birthdate___________Height______Weight_____

Occupation:_______________________ Referring Provider: ____________________________

Are you: ☐ Right handed ☐ Left Handed Gender: ☐ Male ☐ Female

Medications:

☐ NONE ☐ ADDITIONAL SHEET ATTACHED

Medication (include over-the-counter medicines and nutritional supplements)	Reason used	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medical History: Do you currently or have you ever had any of the following, check box and/or circle?

☐ anemia ☐ arthritis ☐ thyroid problems ☐ sleep apnea, use CPAP? YES/NO
☐ hypertension ☐ chronic pain syndrome ☐ circulatory problems ☐ depression ☐ diabetes
☐ stomach ulcers ☐ fibromyalgia ☐ gout ☐ heart disease ☐ pacemaker
☐ use oxygen ☐ HIV/AIDS ☐ hypercholesterolemia ☐ kidney disease ☐ osteoporosis
☐ asthma ☐ psychiatric illness ☐ pregnancy (current) ☐ reflux/heartburn ☐ seizures
☐ COPD ☐ stroke, when?_______ ☐ bleeding disorder ☐ irregular heart beat (A-Fib)

☐ hepatitis, Type?_____________, current or history of
☐ blood clots, When?______________,meds used/procedure done?_______________________________________
☐ alcohol abuse (current/history) ☐ drug abuse (current/history) Please explain:_________________ ______
☐ cancer(s):Please explain(Current or History):____
☐ Other, Please explain____
☐ NONE OF THE ABOVE

Medical Allergies, please list reactions to allergies below:

☐ NONE ☐ penicillin ☐ sulfa
☐ latex ☐ metals ☐ tape ☐ shellfish ☐ Poultry products (chicken/eggs) ☐ iodine, topical ☐ IV contrast dye (Iodine) ☐ other ____________________

Allergy side effects (list medication/product & symptoms of side effect):

____

Surgical History (Circle ALL that apply, please list dates):

☐ NONE
☐ Eyes/ENT cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other__________
☐ Heart bypass, valve replacement, stent, pacemaker, other______________________________
☐ Lung resection, other____
☐ GI appendix, gallbladder, hernia, other _______________________________________
☐ GYN C-section, hysterectomy, tubal ligation, other ______________________________
☐ Urologic prostate, bladder, vasectomy, other____________________________________
☐ Orthopedic joint replacement(please explain), arthroscopy, fracture(s), spine, other__________
☐ Vascular carotid, aneurysm, bypass, other_____________________________________
☐ Neurologic aneurysm, tumor, craniotomy, other___________________________________
☐ Cancer skin, breast, prostate, colon, lung, other_______________________________
☐ Other/Explanation: ____

Anesthesia Complications:

☐ NONE If yes, explain____

Revised: 9/1/2017

Specialists: List any doctors that you see for heart, lung, cancer, other special conditions, Please give names and phone numbers. Please put NONE or N/A if you do not see any other doctors except primary care:

____

____

____

Family History:

- ☐ NONE OF THE BELOW
- ☐ anesthesia complications Father/Mother/Siblings
- ☐ cancer type Father/Mother/Siblings
- ☐ gout Father/Mother/Siblings
- ☐ malignant hyperthermia Father/Mother/Siblings
- ☐ bleeding disorder Father/Mother/Siblings
- ☐ diabetes Father/Mother/Siblings
- ☐ heart disease Father/Mother/Sibling
- ☐ arthritis Father/Mother/Siblings
- ☐ other ____

Social History:

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated

Alcohol use: ☐ no ☐ yes, continue w/below questions

If yes, how often? ☐ monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many drinks on occasion? ☐1-2 ☐3-4 ☐5-6 ☐7-9 ☐10 or more

In the last year, have you ever had 6 or more drinks on one occasion? ☐yes ☐no

If so, ☐monthly or less ☐monthly ☐weekly ☐daily

Tobacco use: ☐ none ☐ previous When quit? _________ ☐ current packs/day____________

Recreational drug use: ☐ none ☐ previous current drug ___________________ last used______

Review of Systems (Circle ALL that apply):

☐ YES	☐ NO	Constitutional	unexpected weight loss, weight gain, chills, fever, night sweats, fatigue
☐ YES	☐ NO	Eyes	blurred/double vision, eye pain, redness, watering, ________________
☐ YES	☐ NO	ENT	headache, difficulty swallowing, nose bleeds, ring in ears, earache ________
☐ YES	☐ NO	Cardiovascular	chest pain, palpitations, murmur, fainting ____________________
☐ YES	☐ NO	Respiratory	shortness of breath, wheezing, coughing, painful breathing, snoring ________
☐ YES	☐ NO	Gastrointestinal	nausea, heartburn, constipation, incontinence, diarrhea, bloody/black stool
☐ YES	☐ NO	Musculoskeletal	joint pain, swelling, instability, stiffness, redness, heat, muscle pain
☐ YES	☐ NO	Dermatologic	skin changes, poor healing, rash, itching, redness ________________
☐ YES	☐ NO	Neurologic	numbness/tingling, unsteady gait, dizziness, tremors, seizures ___________
☐ YES	☐ NO	Psychologic	nervousness, anxiety, depression, hallucinations ________________
☐ YES	☐ NO	Hematologic	easy bleeding/bruising ______________________________
☐ YES	☐ NO	Endocrine	excessive thirst or urination, heat/cold intolerance ______________
☐ YES	☐ NO	Allergic	reactions to food or environment ________________________
☐ YES	☐ NO	Other	______________________________________

Additional information you would like us to know:

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____ ____________________

Patient or responsible party signature **Date**