Patient Registration

Patient

Name_____ Date of Birth_____

Address_____ City, State, Zip_____

Social Security # _____ Home Phone _____

Cell Phone _____ Marital Status: S☐ M☐ D☐ W☐

May we contact you at work? Yes☐ No☐ Work Phone _____

Employer_____ Bank Name _____

Employer Address _____

May we contact you by e-mail? Yes☐ No☐ E-Mail Address _____

Person to Contact in an Emergency_____ Relationship_____

Phone _____

Spouse / Guardian Information

Name_____

Address_____ City, State, Zip_____

Phone _____ Relationship to patient_____

Primary Insurance Company_____

Name of person responsible for account_____

Policy #_____ Group #_____

Social Security #_____Date of Birth_____

Employer_____

Secondary Insurance Company_____

Name of person responsible for account_____ Policy #_____

Group #_____ Social Security #_____

Referring Physician_____ **Primary Care Physician**_____

Notify Primary Care Physician of procedure? Yes☐ No☐

Notify Referring Physician of procedure? Yes☐ No☐

Address to notify Physician_____ Phone _____

Advanced Directives? Yes☐ No☐ ☐I would like information on Advance Directives

If you have a signed Advanced Directives, please bring a copy to the Surgery Facility the day of your procedure.

I have been informed of the Notice of Privacy Practices. I understand that I can obtain a copy of the Notice of Privacy Practices upon request.

I authorize use of this form for ALL of my insurance submissions. I authorize release of medical information to all my insurance companies and any physician or hospital involved in my medical care.

Office Use Only
Advance Directives
☐ *Faxed*
☐ *Mailed*
*Initials*_____
*Date*_____

Name (please print) _____

Signature_____ Date _____

Reviewed by _____Date _____

**It is your responsibility to see that our office has a copy of your current insurance card*

PATIENT MEDICAL HISTORY

Name _____ DOB _____ Age _____ Ht _____ Wt _____

ALLERGIES ☐ LATEX ☐ No known drug allergies ☐ Food ☐ Other
List _____

PERSONAL HEALTH HISTORY (Check all that apply)

Cardiologist ☐ Yes ☐ No Name/Phone # _____ Last Visit _____

Heart Problems ☐ Heart attack ☐ Chest pain ☐ Heart failure ☐ Irregular heart beat
☐ Internal defibrillator ☐ Rheumatic fever ☐ Mitral valve prolapse ☐ Pacemaker ☐ EKG

Comments _____

Lung Problems ☐ Asthma ☐ Emphysema ☐ TB ☐ Chronic lung disease
☐ Shortness of breath ☐ Sleep Apnea ☐ CPAP ☐ Pneumonia

Comments _____

☐ Diabetes
☐ Stroke
☐ High blood pressure
☐ Cancer
☐ Chemotherapy
☐ Radiation therapy
☐ Circulation problems
☐ Bleeding problems
☐ Stomach problems
☐ Other _____
☐ Bowel problems
☐ Hepatitis
☐ HIV
☐ Chicken pox
☐ Depression
☐ Emotional problems
☐ Thyroid problems
☐ Kidney/bladder problems

Comments: _____

Have you ever been diagnosed with or treated for methicillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant enterococci (VRE) or any other multidrug-resistant organism (MDRO)? ☐ Yes ☐ No

Comments _____

Last Menstrual Period _____ Pregnancy _____ Childbirth _____

Previous surgeries with dates _____

_____

_____

Complications to anesthesia? ☐ Yes ☐ No Explain _____

Other hospitalization with dates _____

Family health history (Check all that apply) ☐ High blood pressure ☐ Stroke ☐ Diabetes
☐ Heart disease ☐ Cancer (site) _____ ☐ Other _____

CURRENT MEDICATIONS – See Medication Reconciliation

Tobacco ☐ Yes ☐ No ☐ Stopped Length of time used:	Alcohol ☐ Yes ☐ No Frequency of use:	History of addiction ☐ Yes ☐ No Explain:

Do you feel safe at home? ☐ Yes ☐ No _____

Primary Care Physician _____ Phone # _____

May we contact your primary care physician (PCP) and/or specialist? ☐ Yes ☐ No

Specialist(s) _____

Pharmacy Name _____ Phone # _____
☐ Unknown (per patient)

Clearance ☐ Yes ■ No Regarding: _____

Patient Signature Date/Time

Reviewed By ☐ per phone Date/Time

Updated By ☐ per phone Date/Time

Updated By ☐ per phone Date/Time

PAIN HISTORY QUESTIONNAIRE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Name *(Last, First, M.I.):* ☐ M ☐ F **DOB/Age**:

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Occupation:**

Primary Doctor: **Referring Doctor:**

Do you Drink Alcohol? ☐ Yes (Type/Amount) _____ ☐ No **Do You Smoke?** ☐ Yes (Packs per day) _____ ☐ No

Do You Take Blood Thinners? ☐ No ☐ Yes If yes, what type and how? _____

Do You Use Recreational Drugs? ☐ YES ☐ NO ☐ Never If yes, type and amount per week? _____ Ever Been in Rehab/Detox? ☐ Yes ☐ No

Allergies:

PAIN HISTORY

Pain Level today? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Current Pain Problem:
☐ Neck Pain ☐ Arm Pain ☐ Low Back Pain ☐ Leg Pain ☐ Chest Pain ☐ Abdominal Pain ☐ Pelvic Pain
☐ Other _____

Date of Onset of Pain:
☐ Days ago
☐ Months ago
☐ Years ago
☐ Exact Date
_____

How did Pain Start? ☐ Work Accident ☐ Home Accident ☐ Auto Accident ☐ After Surgery ☐ No Specific Reason
☐ Other

Describe How the Pain Started: _____

_____

Since the pain began, is it: ☐ Getting Worse ☐ Getting Better ☐ About the Same

Which Best Describes Your Pain? (Check as many as apply) ☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Stabbing ☐ Sore ☐ Tingling
☐ Other _____

Do you use an assistive device?
☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Crutches ☐ None ☐ Other _____

What Makes the Pain Worse?

What Makes the Pain Better?

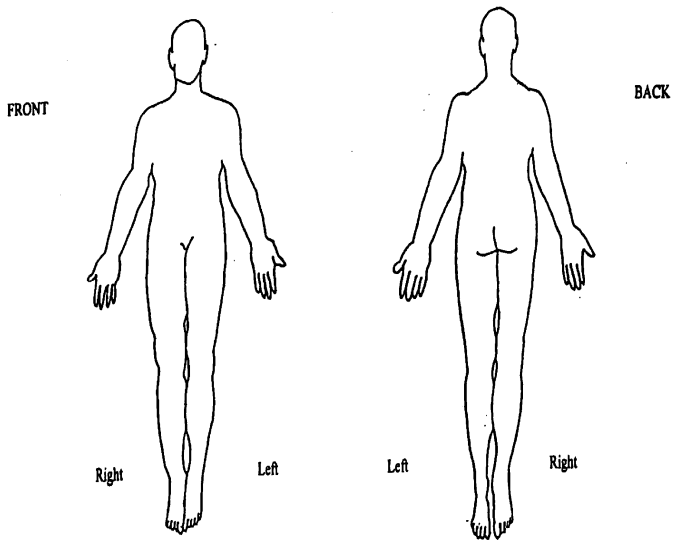
List any medical problems that other doctors have diagnosed:
☐ High Blood Pressure ☐ Diabetes ☐ Ulcers ☐ Heart Problems
☐ Thyroid ☐ Asthma ☐ Kidney Disease ☐ Gout ☐ Rheumatoid
☐ Cancer ☐ Stroke ☐ Bleeding Problems or Bruising Easily
☐ Liver Problems (hepatitis)
☐ Other_____

Previous Treatments for Pain: (Check as Many as Apply)
☐ Physical Therapy ☐ Injections/Nerve Blocks ☐ TENS Unit
☐ Psychological/Counseling ☐ Biofeedback ☐ Chiropractor
☐ Surgery (if yes, detail below) ☐ Other
_____

Have you had any tests for your current problem?
(Check as Many as Apply) ☐ X-rays ☐ MRI ☐ Bone Scan ☐ CT Scan
☐ EMG ☐ Myelogram ☐ Nerve Conduction Test
☐ Other _____

Has the Pain Caused Depression or Emotional Problems?
☐ Yes ☐ No

Mark Areas of Pain On Figure Below:



Approximate Height _____ Weight_____

Epidural Injections discussed with Patient? _____ **Date:** _____

Surgical Treatments for Pain: (Date, Surgeon, Results)

Other Past Surgeries (Other than for pain)

MEDICATION LIST

Patient Name _____ Date _____

ALLERGIES _____

☐ **NKDA** _____

☐ **NKA**

LIST BELOW ALL OF YOUR MEDICATIONS INCLUDING OVER-THE-COUNTER, HERBAL MEDS, DIETARY SUPPLEMENTS, VITAMINS, ANTACIDS, PAIN RELIEVERS & RECREATIONAL DRUGS.

MEDICATION NAME (WRITE LEGIBLY)	DOSE	FREQUENCY	INDICATIONS / REASONS

ADDITIONAL HEALTH INFORMATION

RN Signature _____ ***Date*** _____ ***Time*** _____