

Patient Registration

OrthoTennessee Care Center

MRN # _____

Physician _____

About The Patient

Full Name _____ Last, _____ First _____ MI _____ Maiden Name _____ SSN _____

Birthdate _____ Sex _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Race _____ Language _____ Ethnicity _____ Single Married Divorced Widowed
VOLUNTARY

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Employer _____ Address _____

Occupation _____

Emergency Contact Name _____ Phone # _____

Your Spouse or Parent

Name: _____ Birthdate: _____

Address _____ Phone #: _____

Employer: _____ Emp. Phone #: _____

SSN (if financially responsible) _____

Insurance

Primary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Secondary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Reason For Visit

What body part are we seeing you for? _____ Right Left

This is (check one) Injury Onset of Pain Attourney Involved? Yes No

Date on injury or onset of pain _____

Type of accident: Auto Worker's Comp Other

Referring Physician _____ Primary Physician ^(if different) _____

NOTICE OF FINANCIAL OR INVESTMENT RELATIONSHIP

In order to provide you with the most comprehensive quality care, you may be referred to a facility in which OrthoTennessee physicians may have an ownership interest. This document serves as notice to you of the financial investments or relationships of the physicians of OrthoTennessee. OrthoTennessee physicians have investment interests in the following: Fort Sanders West Outpatient Surgery Center, Advanced Family Surgery Center, Knoxville Orthopedic Surgery Center, OrthoTennessee Therapy, OrthoTennessee Imaging, or OrthoTennessee Orthotics. In addition, your physician may have financial relationships with orthopedic manufacturing companies which produce surgical implants and other orthopedic products that may be used in connection with your treatment.

You may request an alternative provider for your services (physical therapy, MRI, surgery centers). If you would like to seek your medical services elsewhere, please inform your physician and you will be referred to another comparable facility. We assure you that you will not be treated differently at OrthoTennessee if you request an alternative provider. If you have any questions or concerns regarding the above notice or your treatment plan, your physician will be happy to discuss those with you.

Patient/Legal Representative Signature: _____

AUTHORIZATION FOR TREATMENT AND FILING INSURANCE

I authorize consent for treatment, the release of any medical information necessary to process this claim, and authorize payment of medical benefits to OrthoTennessee for services provided. I authorize OrthoTennessee, as part of my medical evaluation and treatment, to access my electronic medication history. I understand that I am financially responsible for the charges covered by this authorization and for collection expenses on unpaid balances.

Patient/Legal Representative Signature: _____ Date _____

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, have been made aware of OrthoTennessee’s Notice of Privacy Practices that is on public display in the lobby and also available on its website (www.orthotennessee.com). I understand that I may request a paper copy of the Notice of Privacy Practices at this location.

Designated Representatives: The following people may call to ask and/or receive medical information for and about me as well as sign for prescriptions that are picked up on my behalf.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

Patient/Legal Representative Signature: _____ Date _____

CONSENT FOR TREATMENT OF MINOR PATIENT

Patient Name: _____ Date of Birth: _____

By signing this form I acknowledge that I am the parent/legal guardian of the above named child and I consent to OrthoTennessee providing medical care, including, but not limited to, physical exams, routine testing and other treatments.

NOTE: legal guardian must provide proof of guardianship (court order, power of attorney, etc.)

I understand that I must be present for the initial office visit or the appointment will need to be rescheduled.

I understand and consent that my child may be seen for follow up appointments/treatments related to the initial office visit with-

Patient/Legal Representative Name: _____

Relationship to Patient: _____

Signature _____ Date _____

OrthoTennessee

Knoxville Orthopaedic Clinic • OrthoTennessee Maryville • OrthoTennessee Oak Ridge • University Orthopaedic Surgeons

MEDICAL HISTORY

Patient's Name _____ Medical Record# _____

Patient's Date of Birth _____ Today's Date _____

Medical History		<input type="checkbox"/> None of the following?	
Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis/Liver disease
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Hypertension/High blood pressure
<input type="checkbox"/>	<input type="checkbox"/> Bipolar	<input type="checkbox"/>	<input type="checkbox"/> Myocardial Infarction/Heart attack
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Peptic ulcer disease
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Renal disease/Kidney disease
<input type="checkbox"/>	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Coronary artery disease/Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/>	<input type="checkbox"/> Deep venous thrombosis/Blood clots	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/> Elevated lipids/High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> HIV /Aids
<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/> Pulmonary embolus/Blood clots in lung
<input type="checkbox"/> Other illnesses currently or chronically treated _____			

Past Surgical History - Have you had any of the following surgeries?			<input type="checkbox"/> None
<input type="checkbox"/> ACL repair	__right __left	<input type="checkbox"/> CABG/Coronary artery bypass	<input type="checkbox"/> Knee replacement
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Cardiac pacemaker	__right __left
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Cardiac valve replacement	<input type="checkbox"/> Meniscus surgery/Knee cartilage
<input type="checkbox"/> Arthroscopy		<input type="checkbox"/> Cholecystectomy/gall bladder	__right __left
<input type="checkbox"/> Back surgery		<input type="checkbox"/> Gastric bypass	<input type="checkbox"/> ORIF/Fracture surgery - body part
<input type="checkbox"/> Neck surgery		<input type="checkbox"/> Hernia repair	__right __left
<input type="checkbox"/> Blood transfusion		<input type="checkbox"/> Hip replacement	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Other surgery		__right __left	<input type="checkbox"/> Tonsilectomy
			<input type="checkbox"/> Hysterectomy

Social History	
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____
If no, <input type="checkbox"/> never used tobacco <input type="checkbox"/> former tobacco user	
Do you use alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____

Family History	
Has anybody in your family had any of these conditions?	
Blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____

Do you have sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on blood thinners?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a latex allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have metal allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Allergies - List all drugs to which you are allergic:	Type of reaction - Example: Skin rash, Nausea, etc.
_____	_____
_____	_____
_____	_____
<input type="checkbox"/> No known allergies	

Medications - Please list all medications you are currently taking including supplements:

<input type="checkbox"/> I am not taking any medications at this time.

OrthoTennessee

Knoxville Orthopaedic Clinic • OrthoTennessee Maryville • OrthoTennessee Oak Ridge • University Orthopaedic Surgeons

REVIEW OF SYSTEMS

Patient's Name _____ Medical Record# _____

Patient's Date of Birth _____ Today's Date _____

Pharmacy - Please list your desired pharmacy in the event you receive a medication order:

Street and City _____

Review of Systems: Do you have any of the following symptoms?

Please mark YES or NO for each condition.

CONSTITUTIONAL Normal

- NO YES
 Fever
 Weight gain
 Weight loss

HEAD, EYES, EARS, NOSE, THROAT

Normal

- NO YES
 Headache
 Hearing loss
 Vision loss

RESPIRATORY Normal

- NO YES
 Cough
 Dyspnea/Short of breath
 Recent Infections
 Wheezing

CARDIOVASCULAR Normal

- NO YES
 Chest pain
 Irregular heartbeat/
palpitations
 Poor circulation

GASTROINTESTINAL Normal

- NO YES
 Abdominal pain
 Diarrhea
 Vomiting
 Reflux

GENITOURINARY Normal

- NO YES
 Dysuria/painful urination
 Hematuria/Bloody urine
 Urinary retention/
unable to urinate
 Frequent bladder infections

NEUROLOGICAL Normal

- NO YES
 Numbness in extremities

PSYCHIATRIC Normal

- NO YES
 Anxiety
 Bipolar
 Depression
 Claustrophobia

SKIN Normal

- NO YES
 Rash
 Skin infection
 Sores that do not heal

MUSCULOSKELETAL

- Negative, except today's
complaint

HEMATOLOGIC Normal

- NO YES
 Bleeding disorders

IMMUNOLOGICAL Normal

- NO YES
 Food allergies
 Environmental allergies

Are there any other medical problems that we should be aware of? _____

To the best of my knowledge the above information is current and correct.

Signature: _____ Date: _____