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 __________ *VOLUNTARY* Ethnicity ________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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 Attorney Involved? ☐ Yes ☐ No

Date on injury or onset of pain ____________

Type of accident: Auto ☐ Worker's Comp ☐ Other ☐

Referring Physician ____________ Primary Physician (if different) ____________

I. 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 Initials: ______________

II. 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 Initials: ______________

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 ______________

You may leave messages containing my medical information at the following phone number(s) without speaking to a person:

______________________ ______________________

Patient/Legal Representative Initials ______________

I have read and understand Sections I, II and III above.

Patient/Legal Representative Signature______________________________ **Date:** ______________________________

CONSENT FOR TREATMENT OF MINOR PATIENT (for non-emancipated minors less than 18 years old)

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 without me being present.

I agree with the above and give consent for the treatment of my minor child.

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

☐ None of the following?

Past	Current	Condition	Past	Current	Condition
☐	☐	Anxiety	☐	☐	Hepatitis/Liver disease
☐	☐	Depression	☐	☐	Hypertension/High blood pressure
☐	☐	Bipolar	☐	☐	Myocardial Infarction/Heart attack
☐	☐	Arthritis	☐	☐	Osteoporosis
☐	☐	Asthma	☐	☐	Peptic ulcer disease
☐	☐	Cancer	☐	☐	Renal disease/Kidney disease
☐	☐	Congestive heart failure	☐	☐	Rheumatoid Arthritis
☐	☐	COPD/Emphysema	☐	☐	Seizures
☐	☐	Coronary artery disease/Heart Disease	☐	☐	Sleep apnea
☐	☐	Deep venous thrombosis/Blood clots	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Thyroid disease
☐	☐	Elevated lipids/High Cholesterol	☐	☐	HIV /Aids
☐	☐	Gout	☐	☐	Pulmonary embolus/Blood clots in lung

☐ Other illnesses currently or chronically treated ______________________

Past Surgical History - Have you had any of the following surgeries? ☐ None

- ☐ ACL repair __right __left
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Back surgery
- ☐ Neck surgery
- ☐ Blood transfusion
- ☐ CABG/Coronary artery bypass
- ☐ Cardiac pacemaker
- ☐ Cardiac valve replacement
- ☐ Cholecystectomy/gall bladder
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip replacement __right __left
- ☐ Knee replacement __right __left
- ☐ Meniscus surgery/Knee cartilage __right __left
- ☐ ORIF/Fracture surgery - body part ____________
- ☐ Rotator cuff repair __right __left
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Hysterectomy

☐ Other surgery ______________________

Social History

Do you use tobacco? ☐ Yes ☐ No Amount ________

If no, ☐ never used tobacco ☐ former tobacco user

Do you use alcohol? ☐ Yes ☐ No Amount ________

Do you have sleep apnea?	☐ Yes	☐ No
Are you on blood thinners?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Do you have a latex allergy?	☐ Yes	☐ No
Do you have metal allergy?	☐ Yes	☐ No

Family History

Has anybody in your family had any of these conditions?

Blood disorder	☐ Yes	☐ No	Family Member________
Heart disease	☐ Yes	☐ No	Family Member________
Stroke	☐ Yes	☐ No	Family Member________
Cancer	☐ Yes	☐ No	Family Member________
Diabetes	☐ Yes	☐ No	Family Member________

Allergies - List all drugs to which you are allergic:

____

____

____

☐ No known allergies

Type of reaction - Example: Skin rash, Nausea, etc.

____

____

____

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

____

____

____

____

☐ I am not taking any medications at this time.

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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:** __________

HISTORY OF INJURY / ILLNESS

Patients Name: ______________________________ DOB: ________________ Today's Date: ____________________

Height: _________ Weight: ________ BP: _______________ (for nurses use only)

What body part (s) are we seeing you for today: ____

Is your injury on the LEFT_______ or RIGHT ____________

Are you right or left hand dominant? ____LEFT ______RIGHT ______ Both

How did this illness/ injury occur? : ____

When did symptoms start (date)? (Be as specific as you can) __________________________________

Please describe your symptoms: ____

Have you been treated for this injury/ illness before? ___ YES ____ NO

If yes, who treated this injury/ illness? __________________________________

When did they treat this injury/illness (exact date if possible)? _______________________________________

What type of treatment have you done for this? (circle all that apply including anything you have tried at home) rest, ice, heat, elevation, Aleve or Ibuprofen , brace, wraps, crutches, cortisone injections, acupuncture, chiropractor, physical therapy, surgery.

____

How long did you use this treatment? (exact date if possible) ______________________________

If this is back or lower limb related, how far can you walk on level ground before it becomes painful? ______________

Did you have x-rays, CT scan, MRI,DEXA or EMG/NCS ? ____ YES ____ NO

If YES then what facility were they performed at? ______________________________ what date? _______________

Do you have a disc or the report? _____ YES ______ NO (if yes, please give it to the front desk or nurses)

On a scale of 1 to 10, with 10 being the worst pain you have ever felt, what is your pain scale today? ____________

IS this a work related injury? ______YES _______NO (if yes, please let front desk or nurses know, as we can NOT bill private health insurance or Tenncare/ Medicare for work related injuries.)

Are you a full or part-time resident of a Nursing Home or Skilled Nursing Facility? ______YES ______NO

If yes, where? ________________________________ for how long? __________________

Are you receiving physical / occupational Therapy at the Nursing home? Yes____ NO _____ how long? ____________

Do you see a Cardiologist? Yes ____ NO _____ who are they? ____

Are you in a pain contract with any pain clinic or physician? _______ YES ______ NO, Who are they? ______________

____ for how long? ____

Have you had the COVID 19 vaccine? Yes_____ NO _____ Date of first shot_________ Date of second ___________