

New Patient Registration Form

Orthopaedic Surgery
Dr. Jeffrey Chase, MD



ORTHOPAEDICS &
MEDICAL SPECIALISTS
ACTIVE PHYSICAL THERAPY

Today's Date: _____ Account # _____
Name: _____ DOB: _____ Preferred Language: _____
Mailing Address: _____ Age: _____ E-Mail: _____
City, State, Zip: _____ SSN: _____
Home Phone: _____ Cell Phone: _____ Marital Status: Married () Single () Widowed () Divorced ()
In case of Emergency, Notify: _____ Sex: Male () Female ()
Phone: _____ Referred by: _____
Relationship to patient: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
ID Number: _____ Group Number: _____ ID Number: _____ Group Number: _____
Mailing Address: _____ Mailing Address: _____
City, State, Zip: _____ City, State, Zip: _____
Name/Policy Holder: _____ Name/Policy Holder: _____
SSN: _____ SSN: _____
DOB: _____ Relationship to Patient: _____ DOB: _____ Relationship to Patient: _____

Employment Information

Employer: _____ Telephone: _____
Mailing Address: _____ City, State, Zip: _____

Responsible Party Information

Name: _____ As the responsible party, I agree that all charges that are not directly paid by
the insurance company will be my responsibility
Mailing Address: _____
City, State, Zip: _____ X _____
DOB: _____ E-Mail: _____ Responsible Party Signature
SSN: _____ Phone: _____

Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature: _____ Date: _____

Medical Release Authorization

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ Date: _____

Cancellation of Scheduled Appointments

I understand that if I have a serious emergency and I am unable to come to my appointment, I will contact the office as soon as possible. In other cases, if I fail to cancel my appointment 24 business hours in advance, I will be charged \$50.00 for the missed appointment.

Signature: _____ Date: _____



Medical Questionnaire

Orthopaedic Surgery

Appointment Date: _____ Chart # _____ Provider _____

BP ____/____ Pulse _____
Temp. _____ Hgt ____/____ Wgt _____

Patient Name (Print) _____

Age _____ [F] [M] Dominant hand [R] [L] Height ____/____ Wgt _____ Did you bring x-rays [Y] [N]

Who requested that you visit this office? (Name) _____ [MD] [PA] [Attorney] [None (Self-Referral)]

★ What is the main reason for this visit? [Pain] [Numbness] [Weakness] [Swelling] [Stiffness] [Other] _____ (c.c.)

★ What body part is involved? Please mark in table below. (Location)

Table with 8 columns for body parts: Neck, Shoulder, Elbow, Hand, Pelvis, Knee, Foot, Back, Arm, Wrist, Finger, Hip, Ankle, Toe. Each cell contains checkboxes for R/L and radiates to.

★ How long ago did it start? ___Days ___Weeks ___Months ___Years. Have you had a problem like this before? [Y] [N] (Duration)

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.
[NO INJURY] [INJURY - Accident/Sport] [INJURY AT WORK] [WORK RELATED - (BUT NO INJURY)] [AUTO ACCIDENT]
ANSWER: _____ COMMENT: _____

★ On a scale of 0-10 (10 is the worst) how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 (Severity)

★ What is the quality of the pain? [Sharp] [Dull] [Stabbing] [Throbbing] [Aching] [Burning] (Quality)

The pain is [Constant] [Comes and goes (Intermittent)]. Does your pain wake you from sleep? [Yes] [No] (Timing)

† Do you have? [Swelling] [Bruise] [Numbness] [Tingling] [Weakness] [loss of control of bowel or bladder] (Assoc. Symp. or Neuro ROS)

Since my problem started, it is [Getting better] [Getting worse] [Unchanged] (Context)

What makes your symptoms worse? [Standing] [Walking] [Lifting] [Exercise] [Twisting] [Lying in bed] [Bending] [Squatting] [Kneeling] [Stairs] [Sitting] [Coughing] [Sneezing] (Modify)

Which makes your symptoms better? [Rest] [Elevation] [Ice] [Heat] [Other] _____ (Modify)

What medications are you taking now (or previously) for this problem? _____ (Modify)

Have you had any of these treatments? Injection [Y] [N] Brace [Y] [N] Physical Therapy [Y] [N] Cane/Crutch [Y] [N] (Modify)

Were you seen in the E.R. for this problem? [Y] [N] Which E.R. _____ Date _____

Are you here today as a result of the E.R. visit? [Y] [N] Who saw you in the E.R. (name) _____ [MD] [PA]

What tests/scans have you had for this problem? [X Rays] [MRI] [CAT scan] [Bone scan] [Nerve Test (EMG) NVC]

Have you already had surgery for a problem in this same area either recently or in the past? [Y] [N] Please list below.

Procedure #1 _____ Surgeon _____ City _____ date _____

Procedure #2 _____ Surgeon _____ City _____ date _____

Current work status? [Regular] [Light duty (How long? ____)] [Not working due to this problem] [Disabled] [Retired] [Student]

When is the last date you worked your regular job. _____

Are you currently receiving or plan to apply for: Disability [Y] [N] Workman's Comp [Y] [N] Unemployment [Y] [N]



Name _____

Appointment Date _____

REVIEW OF SYMPTOMS:

1) M/S Have you had a **prior problem** with this same Orthopaedic condition in the past? Y N (explain below)

Do your **other joints** have Morning stiffness lasting over 30 minutes Joint pain or swelling Back Pain

Gout

Rheumatoid arthritis Osteoporosis **Prior fracture** (which bone)_____ None of the above

Have you had a **Bone Density Scan** for Osteoporosis within 2 years? Y N

ARE YOU HIV POSITIVE? Y N

HAVE YOU HAD ANY OF THESE SYMPTOMS? IF NOT, MARK NONE **None** **Year** **Explain Details/Comments**

- 2) GI Heartburn, ulcers Nausea, vomiting Blood in stool
 Hepatitis Liver disease
- 3) ENDO Thyroid disease Heat or Cold intolerance
- 4) CON Weight loss Frequent Fever Loss of appetite
- 5) EYE Blurred Vision Double Vision Vision loss
- 6) ENT Hearing Loss Hoarseness Trouble swallowing
- 7) CV Chest Pain Palpitations
- 8) RS Chronic Cough Shortness of Breath
- 9) CV Painful Urination Blood in Urine Kidney problems
- 10) SK Frequent Rashes Skin Ulcers Lumps Psoriasis
- 11) NEU Headaches Dizziness Seizures
- 12) PSY Depression Drug/Alcohol addiction Sleep disorder
- 13) HEM Easy bleeding Easy bruising Anemia

HAVE YOU EVER HAD: Heart attack (year)_____ High Blood Pressure Blood clots (year)_____ Stroke

Heart failure ankle swelling Kidney failure Asthma Sulfa allergy Aspirin sensitivity

stomach ulcers bleeding ulcers stomachache taking anti-inflammatories (including Advil / Aleve)

What anti-inflammatories have you already had a problem with?_____

Cancer (Location)_____ I do not have any of the above conditions

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

Diabetes_____ High Blood Pressure_____ Heart disease_____ Rheumatoid Arthritis_____ **None**

† Do any direct relatives have the same condition you are being seen for today? Y N (relation to you)_____

SOCIAL HISTORY:

† Do you use tobacco? Y N Packs per day____ Alcohol use? Y N How often? Daily Other____/week

Marital History: M S D W

How many people live with you?_____

Occupation:_____ Student

Employer:_____

Do you like your job? Y N

Do you plan to be working 6 months from now? Y N



PAST MEDICAL HISTORY:

ARE YOU A DIABETIC? Y N

TREATMENT: Insulin Oral Meds Diet None

WHAT MEDICATIONS DO YOU TAKE? None Please list with dosage! _____

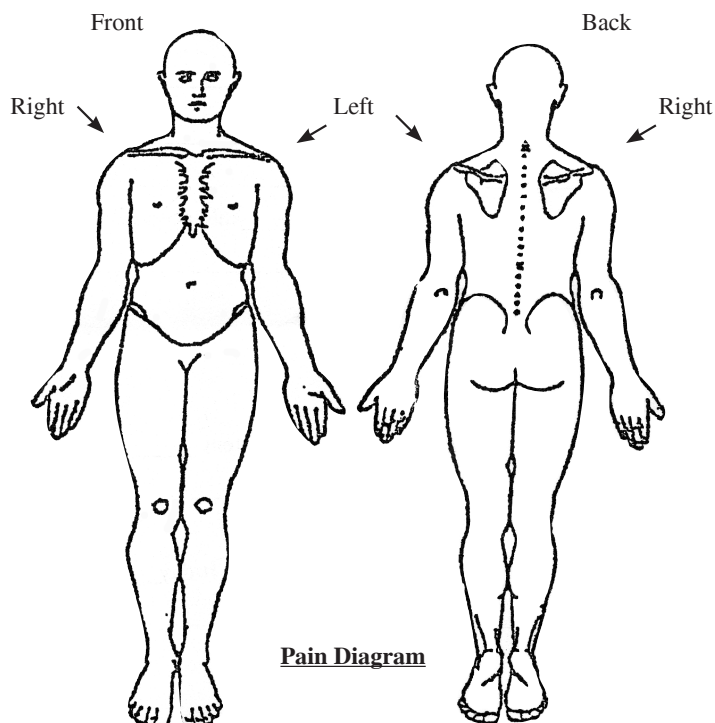
HAVE YOU EVER TAKEN BLOOD THINNERS? Y N

ARE YOU TAKING ANY NOW? Y N

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N If yes, please list and describe reaction _____

PAST SURGICAL HISTORY: What operations have you had? When? None _____

HAVE YOU EVER HAD A REACTION TO ANESTHESIA? Y N



Pain Diagram

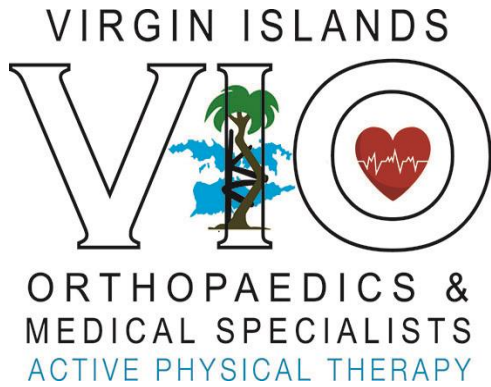
Mark in the areas of your body where you now feel your typical pain. Include all affected areas.

Use the appropriate symbols indicated below:

PAIN = XXXXXX

NUMBNESS = OOOOOO

PLEASE SIGN: The information on these 3 forms is accurate to the best of my knowledge _____



St Thomas Location:
9149 Estate Thomas, Ste 104
St. Thomas, VI 00802
PH: 340.714.2845
FX: 340.714.2843

St Croix Location:
4423 Estate Mary's Fancy
Christiansted, VI 00820
PH: 340.692.5000
FX: 340.692.5002

Cardiology | Orthopaedics | Pain Management | Rheumatology
Rehabilitation | Wellness | Wound Care

Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a **fifty-dollar (\$50) fee**; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a **two hundred dollar (\$200) fee**; this is will not be covered by your insurance company.

4. Account balances

We will require that patients with self-pay balances do pay their account balances to **zero (0)** prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

Print Name Patient

Signature Patient/Guardian

____/____/____
Date

Patient Account # _____

(Office Use Only)