New Patient Registration Form

Interventional Pain Management

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VIRGIN ISLANDS ORTHOPAEDICS & MEDICAL SPECIALISTS ACTIVE PHYSICAL THERAPY

Today's Date:_____ Account #_____

Name: _____ DOB: _____ Preferred Language: _____

Mailing Address:_____ Age: _____ E-Mail: _____

City, State, Zip: _____ SSN: _____ Preferred Pharmacy: _____

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: _____

Mailing Address: _____

City, State, Zip: _____

DOB: _____ E-Mail: _____

SSN: _____

As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility

X _____

Responsible Party Signature

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 Interventional Pain Management

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)

Neck ☐	and radiates to	☐ R arm ☐ L arm ☐ Neither	Shoulder	☐ R ☐ L	Elbow	☐ R ☐ L	Hand	☐ R ☐ L	Pelvis	☐ R ☐ L	Knee	☐ R ☐ L	Foot	☐ R ☐ L
Back ☐	and radiates to	☐ R leg ☐ L leg ☐ Neither	Arm	☐ R ☐ L	Wrist T 2 3 4 5	☐ R ☐ L	Finger T 2 3 4 5	☐ R ☐ L	Hip	☐ R ☐ L	Ankle	☐ R ☐ L	Toe B 2 3 4 5	☐ R ☐ L

★ 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.

ANSWER: **COMMENT:**

☐ **NO INJURY** (Onset was: ☐ Gradual or ☐ Sudden)
Why do you think it started?

☐ **INJURY** - (☐ Accident ☐ Sport NOT Auto or Work)
Date_____. Where and How did it Happen?
What sport_____School_____

☐ **INJURY AT WORK** Date_____.
From a ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach?

☐ **WORK RELATED - (BUT NO INJURY)**
Date_____, How did your job cause this problem?

☐ **AUTO ACCIDENT** Date_____, How was your car hit? (Context)

★ **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 (Modify)
☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

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 _____

_____

_____

_____

_____

_____

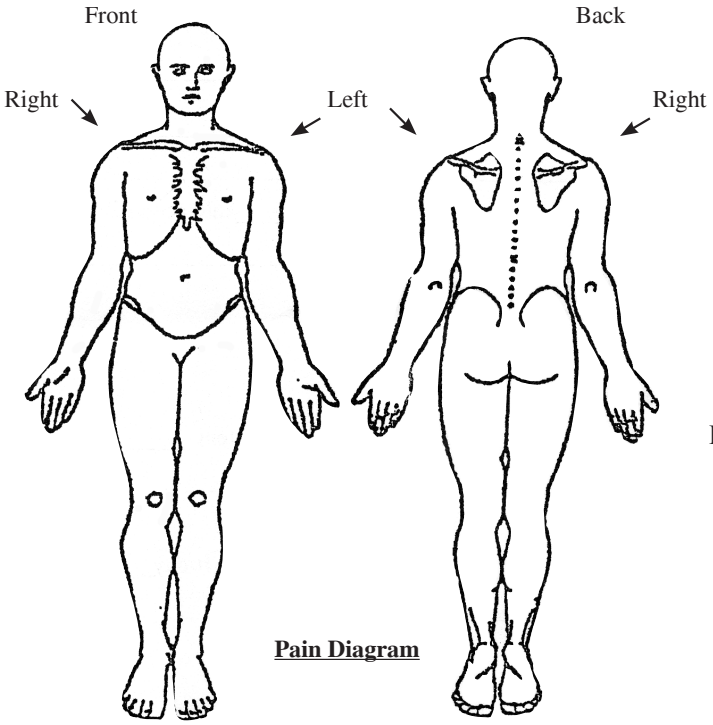
_____

_____

_____

_____

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** _____

VIRGIN ISLANDS
VIO
ORTHOPAEDICS &
MEDICAL SPECIALISTS
ACTIVE PHYSICAL THERAPY

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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)