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PATIENT REGISTRATION FORM

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Social Security #:** _____ **Sex:** ☐M ☐F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____**Work Phone:** _____

Email: _____ **Consent to call?** ☐Yes ☐No **Consent to text?** ☐Yes ☐No

Marital Status: ☐M ☐S ☐D ☐Sep ☐W **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: _____ **Language:** _____

How did you hear about us?

☐My doctor referred me: If so, who is your doctor? _____

☐Athletic team referral: If so, what school/team? _____

☐Hospital ☐Friend/Family Member ☐Advertising ☐Internet Search ☐I was a former patient

☐Insurance Company ☐Other: _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Employer: _____ **Occupation:** _____

Primary Care Physician: _____ **Office:** _____

First Name **Last Name**

Was this injury a result of a motor vehicle accident? ☐Yes ☐No **Were you injured on the job?** ☐Yes ☐No

GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

Name: _____ **DOB:** _____**Patient's relationship to guarantor:** _____

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance:** _____

Policy holder's name: _____ **DOB:** _____**Relationship to patient:** _____

CONSENT

I hereby consent to the necessary treatment for the care of the above named person for whom I am legally responsible. To promote better patient care, I give Orthopaedic Specialists of NC permission to retrieve my medication history.

Signature: _____ **Date:** _____

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HIPAA Consent Form

Patient Name: _____ Date of Birth: _____

The patient or legal guardian has the right to review Orthopaedic Specialists of North Carolina's (OrthoNC) Notice of Privacy Practices and gives permission to the facility to disclose the Protected Health Information (PHI), to the parties below. If no parties are listed, it will be understood that OrthoNC does not have authorization to release information to anyone other than the patient or legal guardian who signs the form.

Name	Relationship	Type of Info to disclose
		Medical Financial Other
		Medical Financial Other
		Medical Financial Other
		Medical Financial Other

By signing below, consent is given to OrthoNC to release medical records to referring providers, primary care physicians, or other providers required for treatment of the patient. Please keep in mind that if the person or entity receiving PHI is not a health care provider or health plan covered by federal privacy regulations, the PHI may be disclosed to other individuals or institutions and no longer protected by these regulations. The patient or legal guardian may inspect or copy the PHI information to be used or disclosed under this authorization. You may revoke or update this authorization in writing at any time by completing a new form or sending written notification to Orthopaedic Specialists of North Carolina. Your revocation or update will not apply to action taken by the requesting person/entity prior to the date any updates or revocations were made.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment.

_____

Signature of Patient or Personal Representative Date

Email Consent:
Standard email correspondence is not a secure means of communication. There is a risk that any PHI contained in standard email may be intercepted by or misdirected to unauthorized 3rd parties. By signing below, the patient or legal guardian acknowledges these potential risks and gives OrthoNC authorization to correspond via email as needed or as initiated by the patient. **As an alternative, patients may use or request access to our Patient Portal where messages may be sent and received in a secure environment.**

_____

Signature of Patient or Personal Representative Date

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OrthoNC Financial Policies
Thank you for choosing Orthopaedic Specialists of North Carolina. We are committed to providing outstanding patient care to you and your family members. Before we provide medical services, we require that you review our financial policies and agree in writing to accept them.

Payment Required at Time of Service
Payment is required at the time of service. This policy applies to applicable estimated coinsurance/deductible and copayments under your health insurance policy, provided we are in-network with your plan. If you do not have health insurance, we require full payment at the time of service. We accept cash, personal checks, Discover, VISA and MasterCard. We do not accept post-dated checks. There is a $25 charge for returned checks.

Policy for Handling Insurance
Our office participates with many health insurance plans. These are listed on our Website, www.orthonc.com. Because each plan is different, we may not have all the details of your insurance benefits. Some of your questions are best answered by a representative of your insurance company. If we are a network provider for your insurance plan, we will submit the claim on your behalf, provided the accurate information has been received in our office within 30 days of the date of service. When you come for your visit, please bring with you a current insurance ID card. If we don't have current insurance information, we automatically consider you a self-pay patient. After we have accurate information on your insurance eligibility and coverage, we will file a claim with your insurance company. If we are a participating provider with your insurance plan, both copayments and estimated co-insurance are due at the time of service. If we are not a participating provider, you are responsible for paying the out-of-network rates at the time of service and filing the claim to your insurance.
In some cases, we may provide you with an estimate for your service. Estimates may differ from the final amount owed once insurance processes your claim. You are responsible for any balance due created by the adjudication of the final claim.

Motor Vehicle Accident Policy
Please be informed that we will bill your health insurance for these injuries. We do not bill automobile policies/insurances. There is no guarantee that these services will be paid by your health insurance. This is to notify you that if there is any delay in payment, or no payment received then you will be financially responsible for these services. Due to the nature of these claims, there could be a delay in receiving statements for these services.

Self Pay Policy
We offer a self pay rate for patients without insurance, which is about 35% of our standard fee. At the initial office visit a self-pay patient will be required to pay $190. This **may not be** the entire amount of the visit. **You will be responsible for the remainder of the balance.** You will be required to pay $90 for each follow up visit, in addition, any remaining balance due on your account. This may not be the entire amount of the visit and you will be responsible for any balance.

Forms
We charge a $15 fee for the completion of each form you ask us to complete on your behalf. Please allow 7-10 days for your form to be completed.

If the Patient is a Minor
An adult parent or guardian accompanying the minor is responsible for the payment of the patient's account regardless of who holds the insurance policy. Unaccompanied minors can be denied non-emergency treatment until a parent or guardian is present or until such time as we receive written permission for the treatment and payment of the account. Unaccompanied minors must provide all co-pays and other payments on the day of service.

Refunds
If an overpayment is made on your account, we will process refunds once a month. If your treatment is ongoing, at your request, we will apply the overpayment to any future balances.

Delinquent Accounts
Patients with an outstanding balance more than thirty (30) days old must make arrangements for payment or pay in full prior to being seen for scheduled appointments. If payment arrangements are not made and the account is more than ninety (90) days delinquent, the account may be turned over to a collection agency. Once the collection agency has your account, you are required to pay the agency directly.
Your balance can be paid directly on our patient portal, over the phone, or in the office. If you wish to set up a payment plan please call our billing department at 919-562-9410 opt 4 prior to your scheduled appointment.

Missed Appointments
If you need to cancel an office visit, please notify our office no less than 24 hours ahead of time so we can reschedule your appointment. If you are unexpectedly delayed, please give us a call so we can make arrangements for you to come at a later time or on a different day.

Surgery Cancellations
A minimum of 72 hours' notice is required to cancel surgery without incurring a $250 fee.

In signing below, you are permitting your insurance payer to remit payment directly to Orthopaedic Specialists of NC and acknowledging that you agree and understand these policies. .

_____

Signature of Patient (or Parent/Guardian)

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PATIENT MEDICAL HISTORY

Name: _____ **Date of Birth:** _____
Referring Doctor: _____ **Primary Care Physician:** _____
Describe your complaints: _____

Medication Allergies/Sensitivities
Please list all allergies or sensitivities to medication and the reaction you have

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Current Medications:

_____	_____
_____	_____
_____	_____

Family History
Please circle all that apply

□	Arthritis	Mother	Father	Brother	Sister
□	Asthma	Mother	Father	Brother	Sister
□	Back Problem	Mother	Father	Brother	Sister
□	Blood Coagulation Disorder	Mother	Father	Brother	Sister
□	Cerebrovascular Accident (stroke)	Mother	Father	Brother	Sister
□	Chronic Obstructive Lung Disease (COPD)	Mother	Father	Brother	Sister
□	Depressive Disorder	Mother	Father	Brother	Sister
□	Diabetes Mellitus	Mother	Father	Brother	Sister
□	Disease of Liver	Mother	Father	Brother	Sister
□	Disorder of Musculoskeletal System	Mother	Father	Brother	Sister
□	Disorder of the Thyroid Gland	Mother	Father	Brother	Sister
□	Familial History of Breast Cancer	Mother	Father	Brother	Sister
□	Family History of Other Cancer	Mother	Father	Brother	Sister
□	Heart Disease	Mother	Father	Brother	Sister
□	Hypercholesterolemia	Mother	Father	Brother	Sister
□	Hypertensive Disorder	Mother	Father	Brother	Sister
□	Kidney Disease	Mother	Father	Brother	Sister
□	Myocardial Infarction (heart attack)	Mother	Father	Brother	Sister
□	Obesity	Mother	Father	Brother	Sister
□	Osteoporosis	Mother	Father	Brother	Sister
□	Rheumatoid Arthritis	Mother	Father	Brother	Sister
□	Substance Abuse	Mother	Father	Brother	Sister

Social History
Please answer or circle all that apply

Education: ☐ Less than 8th grade ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐Associates ☐Bachelors ☐Masters +
Are you currently employed? ☐Yes ☐No
Work Status: ☐ Full-Time ☐ Part-Time **Last Day worked:** ____/____/____
Work related injury? ☐Yes ☐No **Case Manager:** _____
Auto related injury? ☐Yes ☐No **Attorney:** _____

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If injured, is litigation ongoing? ☐Yes ☐No
Able to Care for Self: ☐Yes ☐No
Are you blind or do you have difficulty seeing? ☐Yes ☐No
Are you deaf or do you have serious difficulty hearing? ☐Yes ☐No
Do you have difficulty concentrating, remembering or making decisions? ☐Yes ☐No
Do you have difficulty walking or climbing stairs? ☐Yes ☐No
Do you have difficulty dressing or bathing? ☐Yes ☐No
Do you have difficulty dressing or bathing? ☐Yes ☐No
Marital Status: ☐Married ☐Single ☐Divorced ☐Sep ☐Widow Home Status: ☐Alone ☐With others
Number of children: _____
Smoking Status: ☐Never Smoker ☐Current everyday smoker ☐Smoker-current status unknown
☐Former Smoker ☐Current some day smoker ☐Unknown if ever smoked
Smoking-How much? ☐None ☐1PPW ☐2PPW ☐ ¼ PPD ☐½ PPD ☐1PPD ☐2PPD ☐3+PPD
Chewing Tobacco: ☐None ☐1/day ☐2-4/day ☐5+/day
Tobacco- years of use: _____
Alcohol Intake: ☐None ☐Occasional ☐Moderate ☐Heavy
Alcohol-years of use: _____
Caffeine Intake: ☐None ☐Occasional ☐Moderate ☐Heavy
Illicit Drugs: _____ Years of illicit drug use: _____
Have you ever felt the need to cut back on your drinking or drug use? ☐Yes ☐No
Have you ever been annoyed by someone questioning your use of alcohol or drugs? ☐Yes ☐No
Have you ever felt guilty about something you did while drinking or using drugs? ☐Yes ☐No
Have you ever had to drink alcohol or use a drug first thing in the morning? ☐Yes ☐No

Exercise Level: ☐None ☐Occasional ☐Moderate ☐Heavy
Sports Activities: (Please list all) _____
School you attend: (if applicable) _____

Past Surgical History

Please check all that apply and provide date if known

- ☐ No Significant Past Surgical History
- ☐ Ankle/Foot Surgery _____
- ☐ Appendectomy _____
- ☐ Arthroscopy Ank/kn/sh/elbow _____
- ☐ Back Fusion/Discectomy _____
- ☐ Caesarean Section _____
- ☐ Cardiac Stents _____
- ☐ Fracture Surgery _____
- ☐ Gallbladder Surgery _____
- ☐ Gastrointestinal Surgery _____
- ☐ Hernia Repair _____
- ☐ Hysterectomy _____
- ☐ Neck Surgery _____
- ☐ Oophorectomy _____
- ☐ Open Heart/CABG _____
- ☐ Pacemaker/Defibrillator _____
- ☐ Plastic Surgery _____
- ☐ Thyroid Surgery _____
- ☐ Tonsillectomy/Adenoidectomy _____

Other: _____

Past Medical History

Please check all that apply

- ☐ AIDS/HIV
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Cancer
- ☐ Concussion
- ☐ COPD
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack (MI)
- ☐ Heart Disease/Problems
- ☐ Hepatitis
- ☐ Hernia

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- □ High Cholesterol
- □ History or Infection/MRSA
- □ Hypertension
- □ Kidney Disease
- □ Liver Disease
- □ Migraines
- □ Orthotics
- □ Osteoporosis
- □ Pacemaker
- □ Peripheral Vascular Disease
- □ Pulmonary Embolism
- □ Rheumatoid Arthritis
- □ Seizures/Epilepsy
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers

Review of Systems

Constitutional:

- □ Fever
- □ Night Sweats
- □ Weight Gain
- □ Weight Loss
- □ Exercise intolerance
- □ Lethargy

Eyes:

- □ Dry Eyes
- □ Irritation
- □ Vision Changes

Ears/Nose/Mouth/Throat:

- □ Difficulty Hearing
- □ Ear Pain
- □ Frequent Nosebleeds
- □ Nose Problems
- □ Sinus Problems
- □ Sore Throat
- □ Bleeding Gums
- □ Snoring
- □ Dry Mouth
- □ Oral Abnormalities
- □ Mouth Ulcer
- □ Teeth Abnormalities
- □ Mouth Breathing

Cardiovascular:

- □ Chest pain on exertion
- □ Arm pain on exertion
- □ Shortness of breath when walking
- □ Shortness of breath when lying down
- □ Palpitations
- □ Known Heart murmur
- □ Light-headed on standing

Respiratory:

- □ Cough
- □ Wheezing
- □ Shortness of breath
- □ Coughing up blood
- □ Sleep Apnea

Gastrointestinal:

- □ Abdominal Pain
- □ Nausea
- □ Vomiting
- □ Constipation
- □ Change in appetite
- □ Black or tarry stools
- □ Frequent diarrhea
- □ Vomiting Blood
- □ Dyspepsia
- □ GERD

Genitourinary:

- □ Urinary loss of control
- □ Difficulty urinating

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- □ Increased urinary frequency
- □ Hematuria
- □ Incomplete emptying

Musculoskeletal:

- □ Muscle aches
- □ Muscle weakness
- □ Back Pain
- □ Joint Pain
- □ Swelling in the extremities

Integumentary:

- □ Abnormal Mole
- □ Jaundice
- □ Rash
- □ Itching
- □ Dry Skin
- □ Growths/lesions
- □ laceration

Neurologic:

- □ Loss of Consciousness
- □ Weakness
- □ Numbness
- □ Seizures
- □ Dizziness
- □ Frequent/Severe Headaches
- □ Migraines
- □ Restless legs
- □ Tremor

Psychiatric:

- □ Depression
- □ Sleep Disturbances
- □ Feeling unsafe in relationship
- □ Restless Sleep
- □ Alcohol Abuse
- □ Anxiety
- □ Hallucinations
- □ Suicidal Thoughts

Endocrine:

- □ Fatigue
- □ Increased Thirst
- □ Hair Loss
- □ Increased Hair growth
- □ Cold intolerance

Hematologic/Lymphatic:

- □ Swollen Glands
- □ Easy Bruising
- □ Excessive Bleeding