SPRAINS, STRAINS & FRACTURES, LLC.

Patient Registration

PATIENT INFORMATION

Name (last)________________________(first) ________________________ (mi)___SS#_______________________

Address__________________________________Apt_______City_________________State______Zip____________

Marital Status_______________Birthdate__________________Age_________Sex: (circle) M F Decline to specify

Home Phone_____________________ Cell Phone______________________Email____________________________

Pharmacy Name______________________________Pharmacy Phone_______________________________________

Pharmacy Address____

INSURANCE INFORMATION: **DATE OF ACCIDENT IF AUTO OR WC:______________**

Insurance #1 Type: Health Auto Workers Comp Self Pay
Ins Co Name__________________________________ Subscriber's Name_________________________________

Ins Policy/ID#_________________________________ Subscriber's SSN#_________________________________

Ins Group/Claim#______________________________ Subscriber's Birthdate_____________________________

Does your plan require referrals? Yes No Relationship to subscriber_____________________________

Insurance #2 Type: Health Auto Workers Comp Self Pay

Ins Co Name__________________________________ Subscriber's Name_________________________________

Ins Policy/ID#_________________________________ Subscriber's SSN#_________________________________

Ins Group/Claim#______________________________ Subscriber's Birthdate_____________________________

Does your plan require referrals? Yes No Relationship to subscriber_____________________________

PATIENT'S FAMILY DOCTOR

Group Name______________________________________Address____

Physician's Name__________________________________City/State_______________________________________

Phone____Fax____

WHO REFERRED YOU TO OUR OFFICE?

Name:____Phone____

Address____City/State____

EMERGENCY CONTACT INFORMATION

Name__________________________________ Relationship________________Phone__________________________

Name__________________________________ Relationship________________Phone__________________________

HEALTH HISTORY INFORMATION

PAST MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following?

- ☐ Heart
- ☐ Lungs
- ☐ Liver
- ☐ Kidney
- ☐ Ulcers
- ☐ Seizures
- ☐ Blood Pressure (high/low)
- ☐ Diabetes (Insulin? Y/N)
- ☐ Arthritis
- ☐ Psoriasis
- ☐ Cancer (Type?_____________)
- ☐ Infections
- ☐ Depression/Anxiety
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Psychiatric
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Poor Circulation
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Sleep Apnea

REVIEW OF SYSTEMS

Have you been in good health lately? (Circle) Yes No Height________ Weight________

Are you currently experiencing a problem with any of the following?

Eyes	Yes	No		Musculoskeletal	Yes	No
Ears/Nose/Mouth/Throat	Yes	No		Integumentary(Skin/Breast)	Yes	No
Cardiovascular	Yes	No		Neurological	Yes	No
Respiratory	Yes	No		Psychiatric	Yes	No
Gastrointestinal	Yes	No		Endocrine	Yes	No
Hematological/Lymphatic	Yes	No		Genitourinary	Yes	No
Allergic/Immunologic	Yes	No		Other:		

If you answered yes, please explain each problem.____

____

Do you have history of

Osteoarthritis? Yes No

Rheumatoid arthritis? Yes No If yes, duration_______________________________________

Do you have any shortness of breath, cough, or breathing problems? Yes No

Have you had any

Recent weight gain or loss? Yes No If yes, explain___________________________

Hearing or vision problems? Yes No If yes, explain___________________________

Bowel or bladder problems? Yes No If yes, explain___________________________

Have you or anyone in your family had bleeding problems? Yes No

Are there any diseases that run in the family? Yes No

If yes, please list disease and relation____

Are you left or right handed? Left Right

Do you smoke? Yes No If yes, how often?____

Describe your alcohol use: Heavy Moderate Social None

HEALTH HISTORY INFORMATION (continued)

MEDICATIONS

Do you currently take:

An anti-coagulant medication? (Coumadin, Warfarin, Lovenox, Heparin, Plavix) Yes No

A low dose aspirin (325mg or less) per day? Yes No

Any oral corticosteroids? (i.e. Prednisone) Yes No

Any anti-inflammatory medications? Yes No

List all current medications including prescription, over the counter, and herbal medications:_________

____

____

____

____

ALLERGIES

Are you allergic to any medications? Yes No If yes, please list:______________________________

____

Please list any other relevant allergies (i.e latex, metals, food)__________________________________

____

SURGERY

Have you had any blood transfusions in the past? Yes No

Have you had surgery? Yes No

If yes, please list starting with the most recent surgery:

Date	Type of Surgery	Type of Anesthesia	Problems/Complications
		Local General	
		Local General	
		Local General	
		Local General	
		Local General	
		Local General	
		Local General	

DESCRIPTION OF PROBLEM OR INJURY

Date of Injury________________________ Date you first noticed symptoms________________________

Where did the injury take place? Home Work Motor Vehicle Other____________________________

Please describe your injury including what part of your body is injured and specifically how and where you were injured____

____

____

____

EMPLOYMENT

What is your current work status? Student Employed Unemployed On Disability Retired

Current Employer____________________________ Nature of work____________________________

MEDICAL RELEASE AUTHORIZATION

(This form complies with the HIPPA Privacy Rule)

I hereby authorize: Sprains, Strains & Fractures, LLC and any of its affiliated practices

To disclose the following protected health information to:

Physician/Practice Name____

Address_____________________________________City______________State_______Zip________

Please indicate the information or types of information to be disclosed: All medical records in SSF chart

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

Signature____ Date_____________________

IF YOUR DO NOT WISH THIS INFORMATION TO B RELEASE, INTIAL HERE:___________

ASSIGNMENT OF BENEFITS

I hereby authorize release of my protected health insurance information necessary only for the processing of my claims and authorize payment by my insurance carrier directly to Sprains, Strains & Fractures, LLC. I understand that bills are submitted to my insurance company on my behalf as a courtesy.

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney, or another physician's office. I hereby authorize direct payment of medical/dental and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and any other health plan to Sprains, Strains & Fractures, LLC, and any of its affiliated practices.
I am financially responsible for all charges whether or not paid by insurance.

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information or who conceals, for the purpose of misleading information concerning any fact commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

Signature____Date______________________________

If signed by other than patient, indicate relationship____

NOTICE TO PATIENTS REGARDING REFERRALS

It is the patient's responsibility to get referrals from your family physician. Some insurance companies require patients to have referrals before they have a consultation, procedure, follow-up visit after procedures or office visits. Your insurance company made this policy, we are simply asking you to make sure you have your referrals prior to any healthcare services being rendered.

Also, please note the expiration date of your referral. If your referral has expired, it will be your responsibility to obtain a new referral and not the responsibility of this office. Unfortunately, insurance companies will not let the family doctors backdate a referral. Therefore, if you would still prefer to be seen without a referral, the option will be for you to pay for the entire visit at the time of service. We regret any inconvenience that this referral policy may cause you. However, we are required by the law to abide by the regulations your insurance company has mandated. Thank you for your cooperation with this insurance issue.

HIPAA PRIVACY PRACTICES

I acknowledge that I have received Sprains, Strains & Fractures, LLC's Notice of Privacy Practices.

Your signature below indicates you have read each of the above: (Assignment of Benefits, Referral Notification and HIPAA Privacy Practices).

Signature____Date_______________________________

If signed by other than patient, indicate relationship____

NARCOTIC ANALGESIC AGREEMENT

Dear Patient,

The surgeons at **Sprains, Strains & Fractures, LLC** and our staff welcome you to our practice. We recognize that patients with orthopedic problems who come to our office are here for management of an orthopedic condition of one type or another, which may cause varying degrees of pain. Our goal is to help serve you in the best manner that we can.

Some of the conditions, which we treat, will require physical therapy and some medication for pain relief. Some conditions will require surgical intervention and postoperative pain management.

There are times when we will need to prescribe narcotic analgesics or other controlled substances to help you in managing your acute pain. We require a complete disclosure from you regarding which doctors you treat with and what type of other pain medications you have been prescribed. This is for your safety. If it is discovered at any time during your treatment with us that you are receiving a controlled substance for pain relief from another physician, we will no longer prescribe pain medication for you. This is not something we would like to do and we stress the importance of your compliance with our practice regarding pain medication. We have specific extension for medication renewals and requests will be addressed within the week. Medications can only be renewed during normal business hours Monday through Friday.

If you require long-term pain management, appropriate referral back to your primary care physician or pain management specialists will be made. You are responsible for your medication. If it is lost or stolen, or you have taken more than prescribed for certain amount of time, your prescription **will not be refilled.**

Sincerely,

The physicians at **Sprains, Strains & Fractures, LLC**

I acknowledge and agree to the above contract.

Signature____Date______________________________

If signed by other than patient, indicate relationship____

COVID-19 Questions

1. Have you been diagnosed with COVID-19? **Yes / No**
   If yes, date on onset: ___________________

2. Have you been vaccinated against COVID-19? **Yes / No**
   Approximate dates of vaccination:
   ____

3. Have you had contact with anyone with confirmed COVID-19 in the last two weeks? **Yes / No**

4. Have you had any of the following symptoms in the last two weeks? **Yes / No**
   - Fever greater than 100 degrees
   - Difficulty breathing
   - Cough
   - Loss of smell or taste