Patient Registration

OrthoTennessee Care Center

MRN # _____

Physician _____

About You

Full Name _____ (Last,) _____ (First) ____ (MI) SSN# _____

Birthdate _____ Sex _____

Address _____ City State Zip

Race _____ Language _____ Ethnicity _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

VOLUNTARY

Referring Physician _____ Primary Physician (if different) _____

Home Phone _____ Daytime Phone _____

Cell Phone _____ Email _____

Emergency Contact Name _____ Phone # _____

Employer _____ Address _____

Occupation _____

Your Spouse or Parent

Name: _____ Birthdate: _____

Address _____ Phone #: _____

Employer: _____ Emp. Phone #: _____

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

Injury or Complaint _____

Date on injury or onset of pain _____

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

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		Past	Current	
❑	❑	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
❑ Tonsilectomy
❑ 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:

_____
_____
_____

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

_____
_____
_____

❑ **No known allergies**

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:**_____

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 Signature: _____

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 Signature: _____ Date _____

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 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 _____