G2 Orthopedics and Sports Medicine
Patient Registration Form

Dr. Mr. Mrs. Ms. Jr. Sr. Patient's Name: (Last)______________________(First)__________________ (M.I.)_____

Social Security Number:__________________ Female______ Male______DOB:_______________

Marital Status: (Circle One) Married Single Divorced Widowed Legally Separated

E-Mail Address:_________________________ Employer:___________________________________

Phone Numbers: Work:( )________________ Home: ( )__________________Cell: ( )________________

Street Address: _____________________________________City, State, Zip_________________________________

Emergency Contact: _________________________ Relationship to Patient: ___________ Phone: ( ) ___________

RESPONSIBLE PARTY– If Different from Above: Patient Relationship to Responsible Party_____________________

Responsible Party Name:(L)____________________________(F)_____________________(MI)____

Social Security Number:_________________________Female_____Male________DOB:___________

E-Mail Address:_________________________ Employer:___________________________________

Phone Numbers: Work:( )________________ Home: ( )__________________Cell: ( )________________

Street Address: _____________________________________City, State, Zip_________________________________

Read and Initial Each Item Below

__ I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

__ I acknowledge that I have read the **G2 Orthopedics and Sports Medicine Notice of Privacy Practices**. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

__ I understand that I am financially responsible for all charges resulting from treatment.

Consent for Treatment and Billing

I consent to the use of disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I have the right to revoke this consent, in writing, at any time, except to the extent that G2Orthopedics has acted in reliance on this consent.

Patient Name_____________________________ Signature_____________________________ Date__________

Guardian(Minors)__________________________Signature______________________________Date__________

G2 Representative____________________________________ Date________________

RELEASE OF MEDICAL INFORMATION and /or FINANCIAL INFORMATION(OPTIONAL)

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Medical (please circle)	Financial (please circle)
________________________________	Y N	Y N
________________________________	Y N	Y N

*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name______________________________Signature________________________ DOB___________________

Guardian Name (Minors)____________________Signature________________________ Date____________

G2 Representative_________________________ Date____________

Financial Policies

Most insurance plans include a deductible AND a co-insurance. This means that after you meet your deductible, you will still have a co-insurance. In some cases there is co-payment.

Important Definitions:

1. **Copay:** A copayment or copay is a fixed payment for a covered service, paid when you receive a service. A copayment is a payment defined in an insurance policy and paid by you each time a medical service is accessed.
2. **Deductible**: The amount that you have to pay out-of-pocket for expenses before the insurance company will cover the remaining costs. For example, if you have a deductible of $500.00, you will have to meet that amount before your insurance will cover your surgery.
3. **Coinsurance:** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

- **Our office will obtain an ESTIMATE of your office visit cost.**
- **Our office REQUIRES that your ESTIMATE is paid at the time of your office visit.**
- **If your insurance requires us to collect any additional amount, you will be sent a bill in the mail from our office**

ADDITIONAL CHARGES

- No Show Charge **$25.00** if not notified within 24 hours prior to your appointment.
- Completion of Forms is subject to a $15.00 fee **per form**.
- Copy of your Medical Records is a $10.00 fee plus $0.50 per page for the first 50 pages and $0.25 per page thereafter
- Return Check Fee $30.00

****33% plus court costs and legal fees will be added to accounts sent to collections****

I , ________________________________, have read, understood and agreed to the above terms.
(Print Name)

______________________________ ______________
Patient or Guardian Signature Date

Initial Patient History for New Problem

Patient Name: ____ Age :____________ Handed: Rt Lt Both

HISTORY OF PRESENT PROBLEM

1. Main reason for visit? Pain Numbness Weakness Stiffness Other_______________

2. What **MAIN** body part is involved? (Reason appointment was made)

Shoulder R L	**Elbow** R L	**Hand** R L	Hip R L	**Knee** R L	**Ankle** R L
Arm R L	**Wrist** R L	**Finger** R L			**Foot** R L

3. The problems has been present for: ____Days **OR** ____Weeks **OR** ____Months **OR** ____Years

4. How did your problem begin (**Onset**)?

IF NO INJURY- Began Gradually OR Started Suddenly Why do you think it started? ___________________

Sports Injury- Date: _________ Which sport: __________ How? Fall Twist Pull Hit Other____________

Work Injury- Date: __________ How did it occur? Lift Twist Bend Pull Reach Other ________________

Other Injury- Date: __________ Describe what happened ____

5. **Severity** of pain? Mild 1 2 3 4 5 6 7 8 9 10 Severe

6. **Quality** of pain? Sharp Dull Stabbing Throbbing Aching Burning Other__________

7. **Timing** of pain? Constant Comes & goes **Does** the pain wake you from **sleep?** Yes No

8. Do you have? Swelling Catching Locking Giving way Bruising Numbness Tingling Weakness Loss of bowel or bladder control

9. Since my problem started, it is: Getting better Getting worse Unchanged

10. What makes your symptoms worse? Standing Walking Lifting Exercise Twisting Lying in bed Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

11. What makes it better? Rest Heat Ice Elevation Other______________________________________

12. What medications have you taken for this problem? ____

13. Which treatment have you tried? Injection Brace Therapy Cane/crutch Other:___________________

14. Were you seen in an Emergency Room for this problem? N Y Which ER and date?___________________

15. What tests have you had for this problems? X-rays MRI CAT scan Bone scan Nerve test

16. Have you already had surgery for this problem? N Y Surgeons Name: _________________ Date: ________

G2 NEW PATIENT HISTORY FORM

Patient Information	
Name:	
How did you hear about our Practice?	
☐ Physician (specify below) ☐ Family/Friend ☐ Internet ☐ Trainer/Coach ☐ Sports League ☐ Insurance ☐ Advertising ☐ Other _______	
Preferred Pharmacy	
Referral Source ☐Referring Provider: ________________________ Practice name: ______________________________ *Records may be sent to your referring provider*	Primary Care Physician:_______________________________ Practice name: ______________________________ *Records may be sent to your PCP*
Height: **Weight:** **Race:**	**Ethnicity:** Hispanic Non-hispanic

Past Surgical History *(If none, please mark NONE)*				
Select all previous hospitalizations/surgeries:		**☐ NONE**		
☐ Aneurysm (Brain) Surgery	☐ Hysterectomy	**Orthopedic Surgery:**	**Right**	**Left**
☐ Aortic Bypass / Vascular Surgery	☐ LAP Band / Gastric Bypass Surgery	☐ Arthroscopy: Knee		
☐ Appendectomy	☐ Lumpectomy	☐ Arthroscopy: Shoulder		
☐ Cataract (Eye) Surgery	☐ Mastectomy	☐ Carpal Tunnel Release		
☐ Cholecystectomy (Gallbladder)	☐ Malignancy / Cancer	☐ Rotator Cuff Repair		
☐ Heart Surgery	☐ Stents	☐ Total Hip Replacement		
☐ Hernia Repair		☐ Total Knee Replacement		
☐ Other Surgery:		☐ Total Shoulder Replacement		
		☐ Spinal Surgery - Indicate Level:		
		☐ Other Orthopedic Surgery:		

Medical Questions		Mark all that currently apply:			
☐ Metal in body	☐ Claustrophobic	☐ Pregnant	☐ Sleep Apnea	☐ Use a C PAP	☐ Snores
Are you taking blood thinners?		☐ Yes	☐ No		

Review of Systems	Please indicate if you have experienced any of the following symptoms in the last 6 months *(If none, please mark NONE)*				**☐ None for all**	
					NONE	**COMMENTS**
1) GI	☐ Heartburn, Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐ Stomach Pain		
2) ENDO	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats	☐ Excessive Thirst		
3) CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue			
4) EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐ Headaches		
5) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing			
6) CARDIO	☐ Chest Pain	☐ Palpitations	☐ Faintness/Dizziness			
7) LUNGS	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐ Wheezing		
8) GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems			
9) SKIN	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps			
10) NEURO	☐ Frequent Falls ☐ Change in bladder	☐ Loss of Coordination/Balance ☐ Dizziness	☐ Numbness	☐ Change in Bowel ☐ Seizures		
11) PSYCH	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction		☐ Sleep Disorder		
12) HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia			

Are there any other joints with morning stiffness, swelling, or pain? ☐ Yes ☐ No					
Family History	**Have any direct relatives had any of the following disorders?**				**☐ None for all**
Father	☐ None ☐ Rheumatoid Arthritis	☐ Diabetes ☐ Reaction to Anesthesia	☐ Heart Disease	☐ Hypertension Comments:	☐ Bleeding Problems
Mother	☐ None ☐ Rheumatoid Arthritis	☐ Diabetes ☐ Reaction to Anesthesia	☐ Heart Disease	☐ Hypertension Comments:	☐ Bleeding Problems
Sibling	☐ None ☐ Rheumatoid Arthritis	☐ Diabetes ☐ Reaction to Anesthesia	☐ Heart Disease	☐ Hypertension Comments:	☐ Bleeding Problems

Social History

Do you smoke tobacco?	☐ Daily	☐ Occasionally	☐ Former Smoker	☐ Never	☐ Unknown	# packs/day:
Do you drink alcohol?	☐ Daily	☐ Occasionally	☐ Rarely	☐ Never		
Marital History	☐ Married	☐ Single	☐ Divorced	☐ Widowed	☐ Domestic Partnership	
Are you currently working?	☐ Yes	☐ No	☐ Retired	☐ Disabled		
Occupation:		Employer:			☐ Student	

Personal Medical Information (*If none, please mark NONE*)

ALLERGIES? **☐ Yes** **☐ No**

☐ To Medication(s):

☐ To Food(s):

☐ Other (Latex, etc):

LIST ALL MEDICATIONS you take on a regular basis, including over the counter and supplements: **OR** **☐ None**

Do you have a personal history of any of the following? **OR** **☐ None**

☐ Aneurysm – Where?___________________	☐ Emphysema	☐ Kidney Disease
☐ Angina (chest pain)	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis – Type:	☐ Heart Problems	☐ MRSA Infection
☐ Asthma	☐ Hepatitis – Type:	☐ Pacemaker
☐ Bone or Joint Infections	☐ HIV/AIDS	☐ Phlebitis (Blood Clots)
☐ Cancer – Type: __________	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Chemotherapy/Radiation	☐ Hypertension (High Blood Pressure)	☐ Reaction to Anesthesia – Type: ____________________
☐ COPD	☐ Hyperthyroidism	
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Seizures
☐ Diabetes – Type:	☐ Other: _____________________	☐ Stomach Ulcers
Last A1C:____________		☐ Stroke/TIA
		☐ Tuberculosis