Orthopaedic Associates of Rochester, P.C.

Patient Registration : Page One Personal Information

Last Name	**First Name**	MI:	male ( ) female ( )
Street Address	City	State	Zip
Date of Birth	Social Security Number	married single divorced widowed	
Home Phone	Work Phone	Cell Phone	
Emergency Contact Name / Relationship		Emergency Phone	
Employer Name /Address		Employer Phone	
Your Primary Care Doctor	Doctor's Address	Doctor's Phone	
Other doctor needing reports	Other Doctor's Address	Doctor's Phone	
Your Pharmacy	Pharmacy Address	Pharmacy Phone	
Your Primary Insurance	Contract Number	Insurance Address	
Subscriber Name (if not same as patient)	Subscriber Social Security Number	Subscriber Birthdate	Subscriber Phone
Your Secondary Insurance	Contract Number	Insurance Address	
Subscriber Name (if not same as patient)	Subscriber Social Security Number	Subscriber Birthdate	Subscriber Phone
Is this a WORK RELATED INJURY?	( ) No ( ) YES Date of Injury	Employer	
Compensation Case Number	Comp Carrier & Address	Employer Address	

* * YOU MUST Complete a separate Workers' Compensation Claim Information Form before we can bill your visit as a Compensation Case * *

Is this a MOTOR VEHICLE injury?	( ) No ( ) Yes Date of Injury	Insurance Company Name
Accident Claim Number	Insurance Company Address	Insurance Company Phone

* * YOU MUST complete a separate Motor Vehicle Accident Information Form before we can bill your visit as MVA or No-Fault * *

Is this a SCHOOL injury?	( ) No ( ) Yes Date of Injury	School Name
School Address		Nurse / Coach / Teacher

My signature indicates my consent for Orthopaedic Associates of Rochester to use and release this information for my health care and for OAR business operations. I specifically authorize release of information to file insurance claims and I assign benefits of such claims to OAR.

I understand that I am responsible for any balance not covered by my insurance carrier, and I am responsible for notifying OAR if my insurance coverage changes. If my insurance requires a referral to see an OAR orthopaedist, I understand that it is my responsibility to obtain that referral.

If I fail to pay any sums due, I agree to be responsible for all collection and attorney's fees.

Patient Signature X		Date
If patient is a Minor or Incompetent, Signature of Parent or Guardian:		Relationship Date
If patient is a Minor or Incompetent, Name & Address of Responsible Party:		Responsible Party Social Security #:

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Patient Registration : Page Two: Medical Information

Name: Birth Date: Age: Sex:

Persons living with you: Spouse Adult Child Others
Child Parent

Are you currently working? Occupation:

Are you Allergic to any Drugs or Medications? Please List: **If no drug allergies, please check here ( )**

1 2 3 4

What Medications are you Currently Taking ? (If you brought a list, we can copy it.)

1 2

3 4

Have you been diagnosed with any of the following problems? Please Mark if Yes:

HEENT
O Headaches
O Glaucoma
O Cataracts
O Hearing Loss
O Seasonal Allergies

RESPIRATORY
O Emphysema
O Asthma
O COPD
O Pneumonia
O Tuberculosis
O Pulmonary Embolism
O Respiratory Arrest

BLOOD DISORDERS
O Leukemia
O Lymphoma
O Anemia

CARDIOVASCULAR
O Angina
O Chest Pain
O Coronary Artery Disease
O Congestive Heart Failure
O High Blood Pressure
O Heart Attack
O Irregular Heart Beat
O High Cholesterol
O Vascular Disease
O Reynaud's disease
O Mitral Valve Prolapse
O Stroke / TIA / CVA
O Phlebitis
O Blood clots
O Varicose Veins

ENDOCRINE
O Diabetes - insulin depndnt
O Diabetes - non - insul depnt
O Thyroid disease

GASTROINTESTINAL
O Gastric Ulcer
O GI Bleeding
O Hepatitis
O Crohn's disease
O GERD
O Gastric Reflux
O Liver disease
O Hernia

UROGENITAL
O Kidney stones
O Kidney transplant
O Urinary tract infection
O Enlarged prostate
O Cancer

NEUROLOGIC
O Numbness
O Tingling
O Seizures
O Epilepsy

MUSCULOSKELETAL
O Fracture
O Ligament injury
O Joint replacement
O Osteoarthritis
O Rheumatoid arthritis
O Psoriatic arthritis
O Gout

SYSTEMIC
O Scleroderma
O Lupus
O Immune Disorder

EMOTIONAL
O Depression
O Anxiety
O Alcohol Dependency
O Substance Abuse
O other problems

Please list any surgeries:

date

date

Have you ever had any problems with anesthesia? No If Yes, explain:

Are you pregnant? ( ) yes ( ) no

Do you smoke? ( ) yes ( ) no How much?

Do you drink alcohol? ( ) yes ( ) no How much?

FAMILY HISTORY: Father Living YES NO Mother Living YES NO

If not, cause of death:

Do you have other family history of medical diseases or complications? Please Explain:

Relative: Problem:

Relative: Problem:

Please write any other information that you think your doctor should be aware of on the back of this page.

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Patient Registration : Page Three: CURRENT ORTHOPAEDIC PROBLEM

Name: Birth Date: Today's Date:

Briefly describe the problem that brings you here today:

Was there an accident or injury? If so, when did that happen?

Is this related to your **WORK**? Yes No	Is this a **Motor Vehicle** injury? Yes No	Is this a **sports** injury? Yes No	Have you **reported** this injury? Yes No

Have you been seen for this problem by any medical provider? Please Circle: Private Physician Emergency Department Other
Orthopaedist Company Physician Chiropractor Podiatrist Physical Therapist Other

Please check if you have had: ( ) x-rays ( ) CT scan ( ) MRI ( ) Nerve Study ( ) other test - describe:

For your current problem, have you used any of the following: Cast Splint Brace Cane Crutches Walker
Neck Collar Shoe Insert TENS unit Steroid injection Did this Help?

For your current problem, have you had any previous injuries or surgeries in the same area? Please describe:

If you have been to our office before, has there been any change in your medical history since you were here? Describe:

Review of Systems: PLEASE CIRCLE ANY SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING:

CONSITUTIONAL:	fever fatigue night sweats weight gain weight loss how much?
HEENT:	headaches vision problems hearing problem ear ache
RESPIRATORY:	sore throat cough wheezing shortness of breath
CARDIOVASCULAR:	chest pain palpitations
MUSCULOSKELETAL:	joint pain stiffness deformity weakness instability
GASTROINTESTINAL:	reflux ulcer indigestion loss of appetite irregular bowel symptoms
UROGENITAL:	pain on urination blood in urine irregular menses impotence
SKIN:	rash lesions discoloration lump/bump numbness tingling
NEURO:	dizzyness weakness emotional problems

Your Height: Your Weight: Right or Left Hand Dominant ? Right Left