



## Patient Registration

Referred by: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Nearest Relative/Friend - Phone: \_\_\_\_\_

	Yes	No
Auto Accident	___	___
Workman's Compensation	___	___
Is an Attorney Involved?	___	___

### Insurance Information

**Primary Insurance Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

**Secondary Insurance Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

**Waiver:** I acknowledge that I did not bring a referral as required by my insurance company or I do not have my insurance card. I am electing to be treated today and agree to pay for services rendered since I do not have a valid referral or insurance card.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Pay Physician:** I hereby authorize payment directly to NoVa Orthopedics and Spine. I realize that I am responsible to pay non-covered services. I also understand that I am responsible for any other costs incurred while collecting my outstanding balances.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**In Case of an Emergency Contact**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Office Policy**

We ask for payment for your office visit at the time of service, payable by cash, check, or credit card. A complete itemization of charges will be provided for submittal to your insurance company.

**Authorization to Release Information**

I hereby authorize NoVa Orthopedics to release any information to my employer/insurance company during the course of my examination and treatment. I hereby authorize benefits to be paid to NoVa Orthopedics & Spine Care. I understand that I am responsible for any unpaid balance.

Signature (Guarantor/Patient): \_\_\_\_\_

Date: \_\_\_\_\_

**Patient Intake Form**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Surgeon you are seeing today: \_\_\_\_\_ Referring Doctor/Office: \_\_\_\_\_

Why are you seeing the Doctor today?: \_\_\_\_\_

When was the first time you had this problem? : \_\_\_\_\_

**Past Medical History**

List any previous hospitalizations or surgeries	Date
_____	_____
_____	_____

Do you have any history of bleeding or problems with anesthesia? YES \_\_\_\_\_ NO \_\_\_\_\_

**Medications**

List any medications you are currently taking:	Dosage, # of pills or milligrams	Frequency, # times/day
_____	_____	_____
_____	_____	_____

Have you taken any of the following medications in the last year?

Celebrex \_\_\_\_\_ Bextra \_\_\_\_\_ Vioxx \_\_\_\_\_ Skelaxin \_\_\_\_\_ Naproxyn \_\_\_\_\_ Medrol Dose Pack \_\_\_\_\_

Have you had any physical therapy? \_\_\_\_\_ If yes, how long? \_\_\_\_\_

For what reason: \_\_\_\_\_

**Allergies**

List all medications you are allergic to: \_\_\_\_\_

**Habits**

Do you use tobacco in any form? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Have you ever used IV drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

**Family History**

Do you have a family history of arthritis or disease of the muscles, bones or nervous systems?

If yes, please describe: \_\_\_\_\_

Do you have a family history of bleeding tendencies or anesthesia problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a family history of any other diseases you would like you doctor to know about? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Date Reviewed	Physician Signature	Date Reviewed	Physician Signature

**Patient Intake Form**

**Work/Social History**

Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Is your regular work: Heavy \_\_\_\_\_ Medium \_\_\_\_\_ Light \_\_\_\_\_ Sedentary \_\_\_\_\_

Are you currently working? YES \_\_\_\_\_ NO \_\_\_\_\_ If no, when did you last work? \_\_\_\_\_

Are you currently on any work restrictions? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, what are they? \_\_\_\_\_

What regular exercise or sports do you participate in? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced or separated \_\_\_\_\_

Children: YES \_\_\_\_\_ NO \_\_\_\_\_ How many? \_\_\_\_\_ Ages? \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

**Review of Systems (check any that apply)**

General: recent weight loss or gain \_\_\_\_\_ fatigue \_\_\_\_\_ fever chills \_\_\_\_\_ night sweating \_\_\_\_\_ risk factors for HIV/AIDS \_\_\_\_\_

Skin and Breasts: rashes \_\_\_\_\_ sores \_\_\_\_\_ moles \_\_\_\_\_ lumps \_\_\_\_\_ pain \_\_\_\_\_ excessive bruising \_\_\_\_\_  
nipple discharge \_\_\_\_\_ breast size change \_\_\_\_\_

Ears/Nose/Throat: hearing problems \_\_\_\_\_ sinus problems \_\_\_\_\_ gum or tooth disease \_\_\_\_\_ hoarseness \_\_\_\_\_

Eyes: blurred vision \_\_\_\_\_ double vision \_\_\_\_\_ blind spots \_\_\_\_\_ glaucoma \_\_\_\_\_

Lungs: chronic cough \_\_\_\_\_ wheezing \_\_\_\_\_ coughing blood \_\_\_\_\_ emphysema \_\_\_\_\_ infections \_\_\_\_\_ tuberculosis \_\_\_\_\_  
shortness of breath \_\_\_\_\_

Heart: chest pain \_\_\_\_\_ high blood pressure \_\_\_\_\_ leg swelling \_\_\_\_\_ fainting \_\_\_\_\_ blood clots \_\_\_\_\_

Gastrointestinal: nausea \_\_\_\_\_ heartburn \_\_\_\_\_ ulcers \_\_\_\_\_ swallowing problems \_\_\_\_\_ abdominal pain \_\_\_\_\_  
constipation \_\_\_\_\_ diarrhea bloody stools \_\_\_\_\_

Genitourinary: (female) menopause \_\_\_\_\_ possibility of pregnancy \_\_\_\_\_ incontinence \_\_\_\_\_ painful urination \_\_\_\_\_  
blood in urine \_\_\_\_\_ abnormal vaginal bleeding \_\_\_\_\_ vaginal or pelvic infections \_\_\_\_\_

Genitourinary: Impotence (male) \_\_\_\_\_ incontinence \_\_\_\_\_ painful urination blood in urine \_\_\_\_\_  
trouble starting stream \_\_\_\_\_ prostate problems \_\_\_\_\_

Musculoskeletal: fractures \_\_\_\_\_ muscle or tendon injuries arthritis \_\_\_\_\_ joint swelling \_\_\_\_\_ joint pain \_\_\_\_\_  
childhood deformity or braces \_\_\_\_\_ previous infections \_\_\_\_\_

Neurologic: dizziness \_\_\_\_\_ headache \_\_\_\_\_ slurred speech \_\_\_\_\_ seizures \_\_\_\_\_ numbness or tingling \_\_\_\_\_ weakness \_\_\_\_\_  
stroke \_\_\_\_\_

Endocrine: diabetes \_\_\_\_\_ thyroid trouble \_\_\_\_\_ excessive thirst \_\_\_\_\_ feeling hot or cold when others are comfortable \_\_\_\_\_

Psychiatric: depression \_\_\_\_\_ anxiety \_\_\_\_\_ excessive stress \_\_\_\_\_ considered suicide \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Date Reviewed

Physician Signature

Date Reviewed

Physician Signature




## **Notice of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of these uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

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Patient Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_

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### **Office Use Only**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_



I give permission for NoVa Orthopedic & Spine Care's staff to leave any necessary medical information regarding my care on my answering machine if I am not available.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE NOTICE**

**Please call the office 24 hours in advance to reschedule or cancel and appointment. Please note that \$30.00 charge will be made to your bill for "no-show appointments."**