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PATIENT REGISTRATION

PATIENT INFORMATION

Name ______________________________ DOB ____________

Address ______________________ City ____________ State ______ Zip ________

Home Phone ____________________ Cell Phone ____________________

Social Security Number ______________ Marital Status ☐ S ☐ M ☐ W ☐ D

May we contact you by E-mail? ☐ Yes ☐ No E-mail address ____________________

Employer ______________________________

Employer Address ______________________________

May we contact you at work? ☐ Yes ☐ No Work Phone ____________________

Emergency contact ______________ Relationship __________ Phone __________

Spouse/Guardian Name ______________________________

Spouse/Guardian Address ______________ City ____________ State ______ Zip ________

Spouse/Guardian Phone ______________ Relationship to Patient ______________

INSURANCE INFORMATION

Primary Insurance Company ______________________________

Person Responsible for Account ______________________ SSN # ____________

Policy # ______________________ Group # ______________________

Secondary Insurance Company ______________________________

Person Responsible for Account ______________________ SSN # ____________

Policy # ______________________ Group # ______________________

Insured's Employer ______________________ Address ______________________

Referring Physician ______________________ Primary Care Physician ______________________

Notify primary care physician of procedure? ______________________________

Notify referring physician of procedure? ______________________________

Address to notify physician ______________________ Phone ____________

Advanced Directives? ☐ Yes ☐ No ☐ I would like information on Advanced Directives

If you have a signed Advanced Directives, please bring a copy to the surgery facility on the day of your procedure.

I have been informed of the Notice of Privacy Practices. I understand that I can obtain a copy of the Notice of Privacy Practices upon request. I authorize use of this form for ALL my insurance submissions. I authorize release of medical information to all my insurance companies and any physician or hospital involved in my medical care.

**It is your responsibility to see that our office has a copy of your current insurance card.*

Office Use Only

Advanced Directives

☐ Faxed ☐ Mailed

Initials ______ Date ______

Name (Please Print) ______________________________

Signature ______________________ **Date** ____________

Reviewed By ______________________ **Date** ____________

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PATIENT MEDICAL HISTORY

PATIENT INFORMATION

Name ______ Age ______ DOB ______

Height ______ Weight ______

Allergies ☐ No known drug allergies ☐ Latex ☐ Food
☐ Other (List below) ______

PERSONAL HEALTH HISTORY (Check all that apply)

Cardiologist ☐ Yes ☐ No Name/Phone ______ Last Visit ______

Heart Problems ☐ Heart Attack ☐ Chest Pain ☐ Heart Failure ☐ Irregular Heart Beat ☐ Internal Defibrillator
☐ Rheumatic Fever ☐ Mitral Valve Prolapse ☐ Pacemaker ☐ EKG

Comments ______

Lung Problems ☐ Asthma ☐ Emphysema ☐ TB ☐ Chronic Lung Disease ☐ Shortness of Breath
☐ Sleep Apnea ☐ CPAP ☐ Pneumonia

Comments ______

☐ Diabetes
☐ Stroke
☐ High Blood Pressure
☐ Cancer
☐ Chemotherapy
☐ Radiation Therapy
☐ Circulation Problems
☐ Bleeding Problems
☐ Stomach Problems
☐ Bowel Problems
☐ Hepatitis
☐ Other ______
☐ HIV
☐ Chicken Pox
☐ Depression
☐ Emotional Problems
☐ Thyroid Problems
☐ Kidney/Bladder Problems

Comments ______

Have you ever been diagnosed with or treated for Methicillin-Resistant Staphylococcus Aureus (MRSA), Vancomycin-Resistant Enterococci (VRE) or any other Multidrug-Resistant Organism (MDRO)? ☐ Yes ☐ No

Comments ______

Last Menstrual Period ______ Pregnancy ______ Childbirth ______

Previous surgeries with dates ______

Complications with anesthesia? ☐ Yes ☐ No Explain ______

Other hospitalizations with dates ______

Family health history (Check all that apply) ☐ High Blood Pressure ☐ Stroke ☐ Diabetes ☐ Heart Disease
☐ Cancer (Site) ☐ Other (Please list) ______

Tobacco ☐ Yes ☐ No ☐ Stopped
Length of time used ______

Alcohol ☐ Yes ☐ No ☐ Stopped
Frequency used ______

History of Addiction ☐ Yes ☐ No ☐ Stopped
Please explain ______

Do you feel safe at home? ☐ Yes ☐ No

Primary Care Physician ______ Phone ______

May we contact your primary care physician (PCP) and/or specialist? ☐ Yes ☐ No

Specialist(s) ______

Pharmacy Name ______ Phone ______ ☐ *Unknown per patient*

Clearance ☐ Yes ☐ No Regarding ______

Patient Signature **Date/Time** **Reviewed By** **Date/Time** ☐ *By Phone*

Updated By **Date/Time** **Updated By** **Date/Time** ☐ *By Phone*

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PAIN HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name ______________________ Sex ☐ Male ☐ Female DOB ______________

Marital Status ☐ S ☐ M ☐ W ☐ D Occupation ______________________

Primary Physician ______________________ Referring Physician ______________________

Do you take blood thinners? ☐ Yes ☐ No Have you ever been in rehab/detox? ☐ Yes ☐ No

Allergies ______________________

Pain Level Today (Least Painful) 0 1 2 3 4 5 6 7 8 9 10 (Most Painful)

Current Pain Problem Area ☐ Head ☐ Neck ☐ Arm ☐ Low Back ☐ Leg ☐ Chest ☐ Abdominal ☐ Pelivc ☐ Other ______________________

Date of Onset Pain ______________

How did the pain start? ☐ Work Accident ☐ Auto Accident ☐ After Surgery ☐ No Reason

Explain ______________________

Since the pain started, it is ☐ Worse ☐ Same ☐ Better

Which best describes your pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Sore ☐ Tingling ☐ Other ______________________

Do you use an assistive device? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Crutches ☐ None ☐ Other

What makes the pain worse? ______________________

What makes the pain better? ______________________

List any medical problems that other doctors have diagnosed:
☐ High Blood Pressure ☐ Diabetes ☐ Ulcers ☐ Heart Problems
☐ Thyroid ☐ Asthma ☐ Kidney Disease ☐ Gout ☐ Rheumatoid
☐ Cancer ☐ Stroke ☐ Bleeding Problems/Bruise Easily
☐ Liver Problems (Hepatitis) ☐ Other ______________

Previous treatments for pain: (Check all that apply) ☐ Physical Therapy
☐ Injections/Nerve Blocks ☐ TENS Unit ☐ Psychological/Counseling
☐ Biofeedback ☐ Chiropractor ☐ Surgery (if yes, explain below)
☐ Other ______________________

Have you had any tests for your current problem? (Check all that apply)
☐ X-Rays ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ EMG
☐ Myelogram ☐ Nerve Conduction Test ☐ Other

Has the pain caused depression or emotional problems? ☐ Yes ☐ No

Explain ______________________

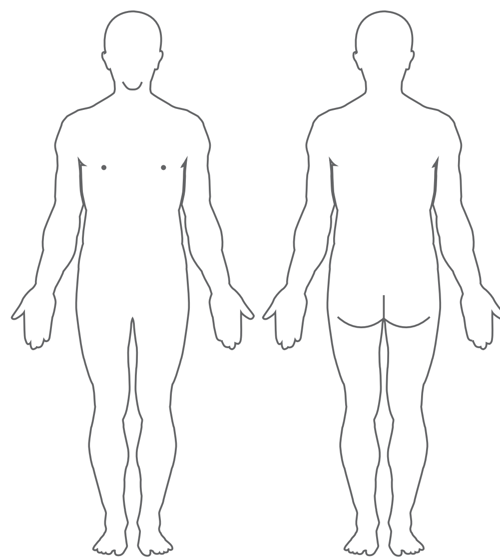
Epidural injections discussed with patient? ☐ Yes ☐ No

Date of discussion ______________________

Surgical treatments for pain? (Date, surgeon, results) ______________

Other past surgeries (Other than for pain) ______________

Mark areas of pain on figures below



Height ________ Weight ________
(Approximate)

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MEDICATION LIST

Date ______________________________

Name ______________________________

ALLERGIES ______________________________

☐ No Known Drug Allergies (NKDA) ______________________________

☐ No Known Allergies (NKA) ______________________________

List below all your medications including over-the-counter, herbal meds, dietary supplements, vitamins, antacids, pain relievers and recreational drugs.

Medication Name (Write Legibly)	Dose	Frequency	Indications/Reasons

ADDITIONAL HEALTH INFORMATION

____

____

____

____

RN Signature ______________________________ Date ______________________________ Time ______________________________