PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____ (First)_____ (MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____ Cell:_____ Work: _____

E-Mail Address:_____ Date of Birth: _____

Pharmacy Name: _____ Pharmacy Location: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Chose not to disclose ☐ other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Other not listed_____

Patient Social Security Number:_____-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____ (First)_____ (MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number: -_____-_____ Phone number: _____

INSURANCE INFORMATION: *Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.*

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

PRIMARY CARE PHYSICIAN INFORMATION:

PCP Name: _____ Phone number: _____

How did you hear about us? Circle any that apply: Website Family/Friend Internet Search

Former or current patient (please provide name so we can thank them!) _____

Physician or Healthcare Facility (please specify): _____

Other (specify): _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____ Date: _____

Printed name of patient or personal representative:_____ Relationship to patient: _____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

[TYPE Location Name]			
Patient Last Name (Type)	Patient First Name (type)	MI	Type Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

_____ **(Patient/Representative initials)** Some messages relevant to your visit may be sent regardless of explicit consent, including instructions or communications directly related to your care. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. For other types of communications, I consent to receiving, by telephone call, text message, or voicemail transmission, communications by or on behalf of the practice/clinic at the email, telephone number or text address I have provided in my patient record. I also consent to receiving such communications to any email, text address or telephone number forwarded or transferred from that address or telephone number. Other healthcare communications may include, but are not limited to, healthcare communications to family or designated representatives regarding my treatment or condition, reminder messages to me regarding appointments for medical care, communications regarding insurance or billing or requests for feedback about my visit via satisfaction surveys and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system for the selection or dialing of telephone numbers or the playing of prerecorded messages and may be made by the practice/clinic or someone calling on their behalf even if my phone number is listed on any federal or state "do not call" registry. To the extent these instructions and other communications could be deemed telephonic sales calls, solicitations or advertisements, I consent to receiving them. I understand that I am not required to consent directly or indirectly to communications in order to receive healthcare services.

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship. My consent to access the location's Electronic Health Record's Patient Portal shall be considered separate and apart from the consent in this form *(section: Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications).*

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? 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:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

[TYPE Location Name]			
Patient Last Name (Type)	Patient First Name (type)	MI	Type Date of Birth (MM/DD/YYYY)

without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

[Practice OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section ONLY if NA to your practice/clinic]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Health History

Today's Date: _____

Name: _____ Date Of Birth: _____ Height: _____ Weight: _____

What are we seeing you for today? (Body part-Right/Left): _____

Is this due to an injury? ☐ Yes ☐ No **When did the injury occur?** If applicable _____

Do you use any of the following?*Circle all that apply* Cigarettes /Cigars /Pipe /Smokeless Tobacco

If yes, how many per day? _____ **Have you ever smoked?** ☐ Yes ☐ No If yes, when did you quit? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week?

Do you or have you used the following in the last three months? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Methamphetamine

Medications	Dosage

Previous Surgery	Date

Is your condition affecting your activities of daily living? ☐ Yes ☐ No

Are you allergic to and medications? ☐ Yes ☐ No If yes, please list: _____

Are you allergic to jewelry/metal? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

What is your current level of pain? 0 1 2 3 4 5 6 7 8 9 10

Have you ever had any of the following? Circle all that apply?

Joint Disease / Stroke / Thyroid / Blood Clot / High Blood Pressure / Tuberculosis / Diabetes / Cancer / Heart Disease

Other: _____

Father

☐ Alive ☐ Deceased

☐ Diabetes ☐ Lung Cancer ☐ Breast Cancer ☐ Heart Disease ☐ Joint Disease ☐ Stroke ☐ Blood Clot ☐ Psychiatric Disorder

Mother

☐ Alive ☐ Deceased

☐ Diabetes ☐ Lung Cancer ☐ Breast Cancer ☐ Heart Disease ☐ Joint Disease ☐ Stroke ☐ Blood Clot ☐ Psychiatric Disorder

Brother

☐ Alive ☐ Deceased

☐ Diabetes ☐ Lung Cancer ☐ Breast Cancer ☐ Heart Disease ☐ Joint Disease ☐ Stroke ☐ Blood Clot ☐ Psychiatric Disorder

Sister

☐ Alive ☐ Deceased

☐ Diabetes ☐ Lung Cancer ☐ Breast Cancer ☐ Heart Disease ☐ Joint Disease ☐ Stroke ☐ Blood Clot ☐ Psychiatric Disorder

Other

☐ Alive ☐ Deceased

☐ Diabetes ☐ Lung Cancer ☐ Breast Cancer ☐ Heart Disease ☐ Joint Disease ☐ Stroke ☐ Blood Clot ☐ Psychiatric Disorder

CONTINUED →

Today's Date: _____

Please Review the following questions carefully and please answer every question.

Systemic

Y	N	Weight Change
Y	N	Chills
Y	N	Fever
Y	N	Night Sweats
Y	N	Feeling tired or poorly

Heads Eyes Ears & Nose

Y	N	Chronic Headaches
Y	N	Eyesight Problems
Y	N	Nosebleeds

Neck

Y	N	Neck Pain
Y	N	Neck Stiffness
Y	N	Lump or Swelling

Pulmonary

Y	N	Shortness of Breath
Y	N	Cough
Y	N	Coughing Up Blood
Y	N	Wheezing

Cardiovascular

Y	N	Chest Pain or Discomfort
Y	N	Fast Heart Rate
Y	N	Palpitations

Genitourinary

Y	N	Blood in the Urine
Y	N	Painful Urination
Y	N	Increased Urinary Frequency

Gastrointestinal

Y	N	Difficulty Swallowing
Y	N	Heart Burn
Y	N	Nausea and/or Vomiting
Y	N	Abdominal Pain
Y	N	Diarrhea

Skin

Y	N	Itching
Y	N	Lesions
Y	N	Rashes

Endocrine

Y	N	Excessive Sweating
Y	N	Excessive Thirst

Psychiatric

Y	N	Sleep Disturbances
Y	N	Anxiety
Y	N	Depression

Management Following Hip, Spine or Distal Radius Fracture

Y	N	Have you ever been diagnosed with a Hip Fracture?
Y	N	Eyesight Problems
Y	N	Nosebleeds

Influenza Vaccine

Y	N	Have you received a flu shot for the **2022-2023** season?
Y	N	Have you ever received a flu shot?
Y	N	If not, was it for medical reasons?
Y	N	If not, was it for non-medical reasons?

Pneumonia Vaccine

Y	N	Have you ever been vaccinated for pneumonia?
Y	N	If not, was it for medical reasons?
Y	N	If not, was it for non-medical reasons?

Advanced Directive

Y	N	Do you have an Advanced Directive or Living Will?
Y	N	If yes, what is your surrogate decision makers name?

Name _____ Relationship

Blood Pressure

Y	N	Been diagnosed with elevated blood pressure (Pre-hypertension)?
Y	N	Been diagnosed with high blood pressure (Hypertension)?
Y	N	Are you currently taking blood pressure medication?

Neurological

Y	N	Dizziness
Y	N	Vertigo
Y	N	Motor Disturbances
Y	N	Sensory Disturbances

Hematological

Y	N	Easy Bleeding
Y	N	Easy Bruising
Y	N	Blood Clot or Embolism

CONTINUED →

Please print full legal name DOB: Date:

Please consider when completing this form, the timelines and symptoms/problems you have had **since the onset** of your **hip or knee pain**. We use this information when we work with your insurance company to authorize viscosupplementation injections and/or hip, knee or shoulder surgery. Your insurer will require documentation and timelines of all conservative therapies and their success and/or failure before they will consider more aggressive treatment or surgical intervention.

WOMAC Index

Rate your pain/stiffness

Please circle one number for every activity listed below using the following scale of difficulty to describe your ability to perform the following tasks:	0 No Difficulty	1 Slightly Difficult	2 Moderately Difficult	3 Very Difficult	4 Extremely Difficult
Walking	0	1	2	3	4
Stair Climbing	0	1	2	3	4
Nocturnal	0	1	2	3	4
Rest	0	1	2	3	4
Weightbearing	0	1	2	3	4
Sleep	0	1	2	3	4
Daily Living	0	1	2	3	4
Morning stiffness	0	1	2	3	4
Stiffness later in the day	0	1	2	3	4
Rate your pain on a scale of 1-10	No Pain 1 2 3 4 5 6 7 8 9 Worst pain ever				
	Is pain constant? Yes/ No		Does the pain come and go?		Yes/No

Rate your physical function

	0	1	2	3	4
Descending stairs	0	1	2	3	4
Ascending stairs	0	1	2	3	4
Sitting	0	1	2	3	4
Rising from sitting	0	1	2	3	4
Bending to the floor	0	1	2	3	4
Standing	0	1	2	3	4
Walking on a flat surface	0	1	2	3	4
Going shopping	0	1	2	3	4
Putting on socks	0	1	2	3	4
Taking off socks	0	1	2	3	4
Lying in bed	0	1	2	3	4
Rising from bed	0	1	2	3	4
Getting in/out of the car	0	1	2	3	4
Getting in/out of the bath	0	1	2	3	4
Getting on/off toilet	0	1	2	3	4
Heavy domestic duties	0	1	2	3	4
Light domestic duties	0	1	2	3	4

Therapies tried and/or completed

Have you had physical therapy?	Yes No	How many sessions? _____	Did it help?	Yes No	
Have you had a recent weight loss?	Yes No	How much weight have you lost? _____			
Do you do a home exercise program?	Yes No	For how long? _____	Did it help?	Yes No	
Use walking aids, e.g. cane, walker?	Yes No	For how long? _____	Did it help?	Yes No	
Have you been on NSAIDS therapy?					
Acetominophen (Tylenol)	Yes No	For how long? _____	Did it help?	Yes No	
Ibuprofen (Advil, Motrin)	Yes No	For how long? _____	Did it help?	Yes No	
Tramadol	Yes No	For how long? _____	Did it help?	Yes No	
Naproxen (Aleve)	Yes No	For how long? _____	Did it help?	Yes No	
Have you had a knee injection with Kenalog or Cortisone?	Yes No	When? _____	Did it help?	Yes No	
Have you had a knee injection with Synvisc, Orthovisc, Hyalgan, Euflexa, GelOne or other viscosupplementlon drug therapy?	Yes No	When? _____	Did it help?	Yes No	

For office use only

Please print full legal name DOB Date:

Sx: **Sx Asst:** **Sx Date:** **CPT Codes:**

KNEE

ACL__TAM__Chrondroplasty__TOTAL

Y	N	R	L	Both	Does patient have severe, disabling pain for at least 6 months?
Y	N	R	L	Both	Is there loss of function that interferes with the ability to perform activities of daily living and/or work?
Y	N	R	L	Both	Is there patient history of giving way or buckling of the knee?
Y	N	R	L	Both	Has patient failed a course of at least 3 month of non-surgical management?
Y	N	R	L	Both	Does patient have a fixed varus or valgus deformity of greater than 30 degrees?
Y	N	R	L	Both	Does patient have osteoporosis or other osseus abnormalities that would make a poor outcome more likely?
Y	N	R	L	Both	Does patient have stable collateral ligaments?
Y	N	R	L	Both	Can patient move the affected knee more than 50 degrees?
Y	N	R	L	Both	Does patient have a severe loss of musculature, neuromuscular compromise, or vascular deficiency in the affected limb?
Y	N	R	L	Both	Is there an acute injury with documented hemarthrosis, effusion and joint instability?
Y	N	R	L	Both	Does MRI, arthroscopy, or arthrogram demonstrate a tear, disruption, or significant laxity of the anterior cruciate ligament?
Y	N	R	L	Both	Is there positive Lachman Test or other appropriate test (e.g. KT-1000, Anterior Drawer, pivot shift) for the diagnosis?
Y	N	R	L	Both	Does your patient have bi or tri-compartmental degenerative arthritis (Kellgren-Lawrence Grade IV) with joint space narrowing on weightbearing x-rays or Modified Outerbridge Classification Grade IV documented by arthroscopy?
Y	N	R	L	Both	Is the plan is to do either bicompartmental or bi-unicompartmental arthroplasty as alternative to standard knee replacement?
Y	N	R	L	Both	Does your patient have inflammatory arthropathy or an active local or systemic infection?

Right McMurray Sign: __ Neg __Mild Pain/Apprehension __Moderate Pain/Apprehension __ Positive/Pop

Left McMurray Sign: __ Neg __Mild Pain/Apprehension __Moderate Pain/Apprehension __ Positive/Pop

VISCOSUPPLEMENTATION

Y	N	R	L	Both	Do your knee(s) produce a noisy, grating sound on active motion?
Y	N	R	L	Both	Does the patient have bony tenderness in the knee(s)?
Y	N	R	L	Both	Does the patient have bony enlargement in the knee(s)?
Y	N	R	L	Both	Do the knees(s) feel warm or inflamed to the touch?

SHOULDER

SCOPE__RCR__TOTAL

Y	N	R	L	Both	Is x-ray or advanced diagnostic imaging conclusive for degenerative joint disease with joint space narrowing and ANY of the following: Irregular joint surfaces, glenoid sclerosis, flattened glenoid, or cystic changes in the humeral head?
Y	N	R	L	Both	Has your patient had chronic, severe disabling pain for at least 6 months?
Y	N	R	L	Both	Does your patient have loss of function that interferes with their ability to perform activities of daily living and/or work?
Y	N	R	L	Both	Has your patient failed a course of at least 6 weeks of non-surgical management?
Y	N	R	L	Both	Does your patient have a current joint or systemic infection?

HIP

TOTAL/CONVERSION

R L Planned total hip procedure: _____Replacement _____Resurfacing

Y	N	R	L	Both	Does patient have femoral head involvement AND acetabular surface WITH joint space narrowing on weightbearing X-ray?
Y	N	R	L	Both	Has diagnostic imaging confirmed inflammatory arthroplathy or early avascular necrosis involving less than 50% of the femoral head with possible acetabular surface involvement?
Y	N	R	L	Both	Does your patient have adequate bone stock to support the device?
Y	N	R	L	Both	Has your patient had severe, disabling pain for at least 6 months?
Y	N	R	L	Both	Does your patient have loss of function that interferes with their ability to perform activities of daily living and /or work?
Y	N	R	L	Both	Has your patient failed a course of at least 3 months of non-surgical management?
Y	N	R	L	Both	Does your patient have any medical condition/disease that would increase mortality/morbidity risk or compromise implant stability or post-operative recovery?
Y	N	R	L	Both	Does your patient have an infection or are they septic, immunosuppressed, or morbidly obese (BMI>39)?
Y	N	R	L	Both	Is your patient a candidate for total hip replacement (THR) AND expected to live longer than a THR will last?
Y	N	R	L	Both	Is your patient younger than 65 years old?