Mid-State Orthopaedic & Sports Medicine Center

New Patient Registration Form

Patient Information

__ Dr __ Miss __ Mr __Ms __ Sir __ Other

Patient's legal name: (Last) _____ (First) _____ (MI) ____ Previous Name _____

Home address _____

City _____ State _____ Zip _____

Mailing address (city, state, zip) _____

Home phone _____ Cell phone _____ Work phone _____ ext _____

Date of birth _____ Sex __ M __ F __ Transgender

Marital status __ Married __ Single __ Divorced __ Widowed __ Legally separated __ Other

Social security number _____ Email address _____

Language _____ Race _____ Ethnicity _____

Employer name _____ Address _____

Occupation _____ Job duties _____

Employment status __ Full time __ Part time __Homemaker __ Self-employed __ Retired __ Active military

Student status __ Full-time student __ Part-time student __ Not a student

Emergency contact: Last name _____ First name _____

Phone number _____ Relationship to patient _____

Contact address _____

City _____ State _____ Zip _____

Responsible Party Information

__ Check if information is the same as above

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

Date of birth _____ Social security number _____

Phone number _____ Email address _____

Sex __ M __ F __ Transgender

Address _____

City _____ State _____ Zip _____

Employer _____ Employer phone number _____

Primary Insurance Information

Insurance company _____ Phone number _____

Name of insured _____ Patient relationship _____

Subscriber ID (Policy #) _____ Group ID _____ Co-pay amount _____

Effective date _____ Date of birth _____

Secondary Insurance Information

Insurance company _____ Phone number _____

Name of insured _____ Patient relationship _____

Subscriber ID (Policy #) _____ Group ID _____ Co-pay amount _____

Effective date _____ Date of birth _____

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

Patient (or responsible party) Signature _____ ***Date*** _____

Patient Name: **Date:** **Form:** PHX

Medical disorders: If you have had any of the following, Place Mark inside Circles

- ○ No Medical History
- ○ AIDS/HIV
- ○ **Alcoholism**
- ○ **Alzheimer's**
- ○ **Anemia**
- ○ **Rheumatoid Arthritis**
- ○ **Asthma**
- ○ **Blood Clot Leg**
- ○ **Blood Clot Lung**
- ○ Stroke
- ○ Cancer Breast
- ○ Cancer **Colon**
- ○ Cancer **Lung**
- ○ Cancer **Prostate**
- ○ **COPD**
- ○ **Depression**
- ○ **Diabetes**
- ○ **Drug Abuse**
- ○ Sleep Apnea
- ○ Gout
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Hepatitis
- ○ Kidney Disease
- ○ Osteoarthritis
- ○ Seizures
- ○ Ulcers, Bleeding

○ **Other Disease** (list below) ○ **Blood thinners (Coumadin, Plavix, aspirin, etc)**

Surgical History: If you have had any of the following, Place Mark inside Circles

- ○ No Surgical History Reported
- ○ Carpal Tunnel Left Wrist
- ○ Arthroscopy Left Elbow
- ○ Arthroscopy Left Shoulder
- ○ Arthroscopy Left Ankle
- ○ Arthroscopy Left Knee
- ○ Arthroscopy Left Hip
- ○ Left Hip Replacement
- ○ Left Knee Replacement
- ○ Spinal Fusion
- ○ Other Surgery (list in the box below)
- ○ Cardiac (Heart)
- ○ Carpal Tunnel Right Wrist
- ○ Arthroscopy Right Elbow
- ○ Arthroscopy Right Shoulder
- ○ Arthroscopy Right Ankle
- ○ Arthroscopy Right Knee
- ○ Arthroscopy Right Hip
- ○ Right Hip Replacement
- ○ Right Knee Replacement
- ○ Laminectomy
- ○ Fracture Surgery

Patient Name: **Date:** **Form:** PFHX

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Mother Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Sibling Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Patient Name: **Date:** **Form:** ROS

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Psychological
- O Nervousness
- O Depression
- O Mood Changes

Patient Name: **Date:** **Form:** SOC

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box

Medication List

Name: _____ Date: _____

Pharmacy: _____ Physician: _____

Height: _____ Weight: _____ Primary Care Physician: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including non-prescription)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____

MID STATE
Orthopaedic & Sports
Medicine Center

3444 Masonic Drive
Alexandria, LA 71301
Phone: (800) 832-7325
(318) 473-9556
Fax: (318) 441-8351

Consent for treatment

I consent to treatment necessary for the care of the patient listed on the front of this sheet. My relationship to this patient is:

Self Spouse Child Other

Release of information and payment policy

I hereby authorize my insurance company/companies to pay directly to Mid State Orthopaedic & Sports Medicine Center any proceeds payable under the terms of my policy/policies. This is an irrevocable assignment and I understand and agree to pay any unpaid balance not covered by my insurance policy. This obligation is to be paid by me. In the event my account is turned over for collection, I hereby agree to pay all collection costs and fees.

I am personally responsible for all charges for treatment rendered at Mid State Orthopaedic & Sports Medicine Center and insurance contractual relationships are between the insurance company and myself.

It is the policy of Mid State Orthopaedic & Sports Medicine Center to assist the patient in obtaining the maximum benefit from their insurance companies. However, we do not withhold our statement or wait until settlements are made before requesting payments.

I acknowledge full financial responsibility for services rendered by Mid State Orthopaedic & Sports Medicine Center.

I agree that Mid State Orthopaedic & Sports Medicine Center may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Further, I give my consent to Mid State Orthopaedic & Sports Medicine Center to release any medical information to my referring physicians, insurance companies, or attorneys.

Signed _____ Date _____

MID STATE
Orthopaedic & Sports
Medicine Center

3444 Masonic Drive
Alexandria, LA 71301
Phone: (800) 832-7325
(318) 473-9556
Fax: (318) 441-8351

Payment Authorization of Medical Benefits

Date: _____

Patient: _____

I request that payment of authorized medical benefits be made either to me or on my behalf to **Mid State Orthopadic & Sports Medicine Center** for any services furnished to me by that provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of patient or authorized representative:

Signed _____ Date _____

I acknowledge that the notice of privacy practice from Mid State Orthopaedic & Sports Medicine Center is available and it is my responsibility to request a copy and read its contents.

Signature of patient or authorized representative:

Signed _____ Date _____

MID STATE
Orthopaedic & Sports
Medicine Center

3444 Masonic Drive
Alexandria, LA 71301
Phone: (800) 832-7325
(318) 473-9556
Fax: (318) 441-8351

Release of Information Agreement

Date: _____

Patient: _____

I am authorizing that the following individuals (if any) may have access to information about my medical condition at this clinic.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

( ) No individual is authorized to access my medical information.

Signature of patient or authorized representative:

Signed _____ Date _____

Relationship to patient: _____

MID STATE
Orthopaedic & Sports
Medicine Center

3444 Masonic Drive
Alexandria, LA 71301
Phone: (800) 832-7325
(318) 473-9556
Fax: (318) 441-8351

Payment Authorization of Medicare Benefits

Date: _____

Patient: _____ DOB: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mid State Orthopaedic & Sports Medicine Center for any services furnished to me by that provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of patient or authorized representative:

Signed _____ Date _____

I acknowledge that the notice of privacy practice from Mid State Orthopaedic & Sports Medicine Center is available and it is my responsibility to request a copy and read its contents.

Signed _____ Date _____