KOMAN

ORTHOPEDICS & SPORTS MEDICINE

Patient Registration Form

Personal Information	Today's Date:	
Last Name:		
First Name:	Middle Initial:	
Address:		DOB:
City:		Sex (M or F):
State:	Marital Status:	
Zip Code:	Email Address:	
Home Phone:	Social Security #:	
Work Phone:	Employer:	
Cell Phone:		
Primary Care Physician:	PCP Phone:	
Referring Physician:		
Other referral source:		
Responsible Party Name:	SS#:	DOB:
Insured:		
Relationship to Insured:		
Insurances: Primary:	Subscriber ID:	
Secondary:	Subscriber ID:	
Workers' Compensation Information (if applicable):	Claim Number: Adjuster Name: Adjuster Phone:	
Emergency Contact Name:		
Emergency Contact Number:	Relationship:	

INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

NAME: _____

Age: _____ **Today's Date:** _____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us?
Please give name of person/physician:

_____

Your Occupation:

_____

Where is your problem? (please circle)

Shoulder	Elbow	Wrist/Hand
Knee	Hip	Ankle/foot
Back	Neck	Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please circle all that apply):
- Pain
- Weakness
- Instability /giving way /dislocation
- Stiffness
- Swelling
- Other _____

How did you injure yourself?
- No injury
- Sports (which sport?) _____
- Motor vehicle accident
- Work/ job -
  - Workers claim? Yes / No

Date of injury? _____

Sports level: none/recreational/college/ professional

How long have you had symptoms?
_____**Days** _____**Mos.** _____ **Yrs.**

Please briefly describe the injury:

_____

_____

Diagnosis (if you know or have been told)?

_____

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)

_____

_____

How severe is the pain? *(0 = none, 10 = severe pain)*
At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have night pain? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired
Normal job? Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any previous imaging studies?

X-rays	Yes / No	date: _____
MRI	Yes / No	date: _____
CT scan	Yes / No	date: _____
Other	Yes / No	date: _____

INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

PAST MEDICAL HISTORY:

- ☐ High blood pressure _____
- ☐ Heart problems _____
- ☐ History of heart attack _____
- ☐ Stroke _____
- ☐ Kidney disease _____
- ☐ History of Cancer _____
- ☐ Osteoporosis _____
- ☐ Blood clot/embolus _____
- ☐ Blood clotting disorder _____
- ☐ Diabetes _____
- ☐ Skin infections _____
- ☐ MRSA _____
- ☐ Other _____

ALLERGIES:

- ☐ NO KNOWN DRUG ALLERGIES
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

SOCIAL HISTORY:

Marital status: _____

Alcohol use: ☐ Daily ☐Socially ☐ Never

Tobacco use: ☐ Yes - Packs per day _____

☐ No

MEDICATIONS: (please list all medications you are currently taking)

_____

_____

_____

_____

_____

_____

_____

_____

SURGICAL HISTORY:

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY:

	DIABETES	HYPERTENSION	HEART DISEASE	STROKE	MENTAL ILLNESS	CANCER	UNKNOWN	NO KNOWN FAMILY HISTORY
FATHER	☐	☐	☐	☐	☐	☐	☐	☐
MOTHER	☐	☐	☐	☐	☐	☐	☐	☐
SON(S)	☐	☐	☐	☐	☐	☐	☐	☐
DAUGHTER(S)	☐	☐	☐	☐	☐	☐	☐	☐
PATERNAL GM	☐	☐	☐	☐	☐	☐	☐	☐
PATERNAL GF	☐	☐	☐	☐	☐	☐	☐	☐
MATERNAL GM	☐	☐	☐	☐	☐	☐	☐	☐
MATERNAL GF	☐	☐	☐	☐	☐	☐	☐	☐

INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

REVIEW OF SYSTEMS:

-GENERAL ☐ None ☐ Recent weight change ☐ Fever ☐ Weakness/fatigue
☐ Other _____

-EYES ☐ None ☐ Vision change ☐ Glasses/Contacts ☐ Glaucoma ☐ Cataracts
☐ Other _____

-EARS, NOSE, THROAT ☐ None ☐ Loss of hearing ☐ Ear ache/infection ☐ Ringing in ear ☐ Hoarseness
☐ Other _____

-CARDIOVASCULAR ☐ None ☐ Chest pain ☐ Swelling in legs ☐ Shortness in breath ☐ Palpitations
☐ Other _____

-RESPIRATORY ☐ None ☐ Shortness of breath ☐ Wheezing/Asthma ☐ Frequent Cough
☐ Other _____

-GASTROINTESTINAL ☐ None ☐ Heartburn ☐ Acid Reflux ☐ Nausea or Vomiting ☐ Abdominal pain
☐ Other _____

-MUSCULOSKELETAL ☐ None ☐ Arthritis/joint stiffness ☐ Muscle Aches ☐ Swelling of Joints
☐ Other _____

-SKIN ☐ None ☐ Rash ☐ Ulcers ☐ Abdominal Scars ☐ Sores
☐ Other _____

-NEUROLOGICAL ☐ None ☐ Headaches ☐ Fainting/Blackouts ☐ Numbness, tingling, loss of sensation ☐ Dizziness
☐ Other _____

-PSYCHIATRIC ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swing
☐ Other _____

-ENDOCRINE ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot Flashes
☐ Other _____

-HEMATOLOGICAL ☐ None ☐ Easy bruising ☐ Easy bleeding ☐ Anemia
☐ Other _____

Signature: _____ **Date:** _____

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ORTHOPEDICS & SPORTS MEDICINE

Authorization and Assignment of Insurance Benefits

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees to the following:

1. I authorize payment of medical benefits to the provider rendering services.

2. I agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, services rendered or service to be rendered without obtaining my signature on each and every claim submitted for myself and or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

3. I will pay to Koman Orthopedics and Sports Medicine any balance due for services rendered. I understand that if full payment is not made on my behalf by my (insurer, legal representation, or workers compensation insurance) I will be responsible for any outstanding balance.

4. Accounts are considered past due after 30 days. A service charge of $25 plus the rebilling fee will be added to your account if your check is returned from your bank for any reason. Bills turned over to our collection agency will be subject to a collection surcharge of 30% of the account balance. Other fees will apply if the account is forwarded to an attorney for a collection lawsuit. **Any additional medical services will be suspended until your account is paid in full.**

I agree to the statements set forth above in the authorization and assignment of insurance benefits.

_____ _____

Patient Signature (or agent/representative) Date

_____

Print Name

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ORTHOPEDICS & SPORTS MEDICINE

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Koman Orthopedics and Sports Medicine Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)

Patient's Date of Birth

Signature of Patient or Parent/Legal Guardian

Date

provide By HCSI

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ORTHOPEDICS & SPORTS MEDICINE

Patient Consent for Alternate Contact and Patient Information Exchanges

I hereby give my consent for Koman Orthopedics and Sports Medicine (KOSM) to disclose protected health information including appointment reminders or test results about me or my dependent to the following trusted persons in conformance with KOSM's Notice of Privacy Practices. KOSM's Notice of Privacy Practices more completely describes why and how such information may be disclosed.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Name: _____

Relation to Patient: _____

Phone Number: _____

Name: _____

Relation to Patient: _____

Phone Number _____

Name: _____

Relation to Patient: _____

Phone Number: _____

_____ _____

Signature of Patient Date

_____ _____

Print Patient's Name Print Name of Legal Guardian (if applicable)