

KNOXVILLE ORTHOPAEDIC CLINIC
PATIENT REGISTRATION

Date: _____ Medical Record: _____

Patient Name: _____
(Last) (First) (Middle) (Maiden)

Address: _____
(Street) (Apt) (City) (State) (Zip)

Home Phone: () _____ Cell Phone: () _____

Birthdate: _____ Age: _____ Sex: _____ Marital Status: _____

Social Security #: _____ Email: _____

Employer: _____ Work Phone: _____

Work Address: _____

Primary Care Physician: _____

Referring Physician (If different from primary care): _____

Injury or Complaint: _____

Date of Injury or Onset: _____ Is legal action required? _____

Type of Accident: Auto _____ Workmen's Comp _____ Other _____

Spouse/Parent Information

Spouse/Parent Name: _____

Social Security #: _____ Date of Birth _____

Home Address: _____

Work Address: _____

Spouse/ Parent Email: _____

Primary Insurance Name: _____

Secondary Insurance Name: _____

NOTICE OF FINANCIAL OR INVESTMENT RELATIONSHIP

In order to provide you with the most comprehensive quality care, you may be referred to a facility in which OrthoTennessee physicians may have an ownership interest. This document serves as notice to you of the financial investments or relationships of the physicians of OrthoTennessee. OrthoTennessee physicians have investment interests in the following: Fort Sanders West Outpatient Surgery Center, Advanced Family Surgery Center, Knoxville Orthopedic Surgery Center, OrthoTennessee Therapy, OrthoTennessee Imaging, or OrthoTennessee Orthotics. In addition, your physician may have financial relationships with orthopedic manufacturing companies which produce surgical implants and other orthopedic products that may be used in connection with your treatment.

You may request an alternative provider for your services (physical therapy, MRI, surgery centers). If you would like to seek your medical services elsewhere, please inform your physician and you will be referred to another comparable facility. We assure you that you will not be treated differently at OrthoTennessee if you request an alternative provider. If you have any questions or concerns regarding the above notice or your treatment plan, your physician will be happy to discuss those with you.

Patient/Legal Representative Signature: _____

AUTHORIZATION FOR TREATMENT AND FILING INSURANCE

I authorize consent for treatment, the release of any medical information necessary to process this claim, and authorize payment of medical benefits to OrthoTennessee for services provided. I authorize OrthoTennessee, as part of my medical evaluation and treatment, to access my electronic medication history. I understand that I am financially responsible for the charges covered by this authorization and for collection expenses on unpaid balances.

Patient/Legal Representative Signature: _____ Date _____

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, have been made aware of OrthoTennessee’s Notice of Privacy Practices that is on public display in the lobby and also available on its website (www.orthotennessee.com). I understand that I may request a paper copy of the Notice of Privacy Practices at this location.

Designated Representatives: The following people may call to ask and/or receive medical information for and about me as well as sign for prescriptions that are picked up on my behalf.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

You may leave messages containing my medical information at the following phone number(s) without speaking to a person:

Patient/Legal Representative Signature: _____ Date _____

CONSENT FOR TREATMENT OF MINOR PATIENT

(for non-emancipated minors less than 18 years old)

Patient Name: _____ Date of Birth: _____

By signing this form I acknowledge that I am the parent/legal guardian of the above named child and I consent to OrthoTennessee providing medical care, including, but not limited to, physical exams, routine testing and other treatments.

NOTE: legal guardian must provide proof of guardianship (court order, power of attorney, etc.)

I understand that I must be present for the initial office visit or the appointment will need to be rescheduled.

I understand and consent that my child may be seen for follow up appointments/treatments related to the initial office visit without me being present.

I agree with the above and give consent for the treatment of my minor child.

Patient/Legal Representative Name: _____

Relationship to Patient: _____

Signature _____ Date _____

OrthoTennessee

Knoxville Orthopaedic Clinic • Maryville Orthopaedic Clinic • Orthopaedic Surgeons of Oak Ridge • University Orthopaedic Surgeons

KOC REVIEW OF SYSTEMS

Patient's Name _____ Medical Record# _____

Patient's Date of Birth _____ Today's Date _____

Pharmacy - Please list your desired pharmacy in the event you receive a medication order:

Street and City _____

Review of Systems: Do you have any of the following symptoms?

Please mark **YES** or **NO** for each condition.

CONSTITUTIONAL Normal

- | NO | YES |
|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Fever |
| <input type="checkbox"/> | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> | <input type="checkbox"/> Fatigue |

HEAD, EYES, EARS, NOSE, THROAT Normal

- | NO | YES |
|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Headache |
| <input type="checkbox"/> | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> Vision loss |

RESPIRATORY Normal

- | NO | YES |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Cough |
| <input type="checkbox"/> | <input type="checkbox"/> Dyspnea/Short of breath |
| <input type="checkbox"/> | <input type="checkbox"/> Recent Infections |
| <input type="checkbox"/> | <input type="checkbox"/> Wheezing |

CARDIOVASCULAR Normal

- | NO | YES |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular heartbeat/
palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> Poor circulation |

GASTROINTESTINAL Normal

- | NO | YES |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> Reflux |

GENITOURINARY Normal

- | NO | YES |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Dysuria/painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> Hematuria/Bloody urine |
| <input type="checkbox"/> | <input type="checkbox"/> Urinary retention/
unable to urinate |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent bladder infections |

NEUROLOGICAL Normal

- | NO | YES |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Numbness in extremities |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness |

PSYCHIATRIC Normal

- | NO | YES |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> | <input type="checkbox"/> Insomnia |

SKIN Normal

- | NO | YES |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Skin infection |
| <input type="checkbox"/> | <input type="checkbox"/> Sores that do not heal |

MUSCULOSKELETAL

- Negative, except today's complaint

HEMATOLOGIC Normal

- | NO | YES |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding disorders |

IMMUNOLOGICAL Normal

- | NO | YES |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Environmental allergies |

Are there any other medical problems that we should be aware of? _____

To the best of my knowledge the above information is current and correct.

Signature: _____ Date: _____

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MEDICAL HISTORY

Patient's Name _____ Medical Record# _____

Patient's Date of Birth _____ Today's Date _____

Medical History		None of the following?	
Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis/Liver disease
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Hypertension/High blood pressure
<input type="checkbox"/>	<input type="checkbox"/> Bipolar	<input type="checkbox"/>	<input type="checkbox"/> Myocardial Infarction/Heart attack
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Peptic ulcer disease
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Renal disease/Kidney disease
<input type="checkbox"/>	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Coronary artery disease/Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/>	<input type="checkbox"/> Deep venous thrombosis/Blood clots	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/> Elevated lipids/High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> HIV /Aids
<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/> Pulmonary embolus/Blood clots in lung
<input type="checkbox"/> Other illnesses currently or chronically treated _____			

Past Surgical History - Have you had any of the following surgeries?			None	
<input type="checkbox"/> ACL repair	__right __left	<input type="checkbox"/> CABG/Coronary artery bypass	<input type="checkbox"/> Knee replacement	__right __left
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Cardiac pacemaker	<input type="checkbox"/> Meniscus surgery/Knee cartilage	__right __left
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Cardiac valve replacement	<input type="checkbox"/> ORIF/Fracture surgery - body part	_____
<input type="checkbox"/> Arthroscopy		<input type="checkbox"/> Cholecystectomy/gall bladder	<input type="checkbox"/> Rotator cuff repair	__right __left
<input type="checkbox"/> Back surgery		<input type="checkbox"/> Gastric bypass	<input type="checkbox"/> Thyroidectomy	
<input type="checkbox"/> Neck surgery		<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Blood transfusion		<input type="checkbox"/> Hip replacement	__right __left	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Other surgery _____				

Social History	
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____
If no, <input type="checkbox"/> never used tobacco <input type="checkbox"/> former tobacco user	
Do you use alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____

Family History	
Has anybody in your family had any of these conditions?	
Blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Family Member _____

Do you have sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on blood thinners?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a latex allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have metal allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Immunizations	
Have you had a Flu Vaccine in the last 12 mo.?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date _____
Have you had a Pneumonia Vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date _____

Allergies - List all drugs to which you are allergic:	Type of reaction - Example: Skin rash, Nausea, etc.
_____	_____
_____	_____
_____	_____
<input type="checkbox"/> No known allergies	

Medications - Please list all medications you are currently taking including supplements:

<input type="checkbox"/> I am not taking any medications at this time.

KOC PAIN MEDICATION MANAGEMENT AGREEMENT

The following information regarding pain medication use (opioids/narcotics), is important for you to understand prior to a KOC physician providing you with any treatment.

- 1) You must disclose any medications currently being provided to you by any other provider. Failure to do this may result in our inability to continue your treatment.
- 2) If your treatment by KOC results in a surgical procedure, and if you are currently receiving pain medications from another provider, you need to make arrangements with that provider for any pain medications you may require during the pre and post-operative period.
- 3) If you receive narcotic pain medications from a KOC physician, you are not to receive any narcotics from another physician while you are under the care of a KOC physician.
- 4) No narcotic pain medication will be prescribed outside of office hours.
- 5) Lost/stolen medications or prescriptions for medication will NOT be replaced.
- 6) Pain medications will not be refilled after 2 months from your last visit with your KOC physician unless otherwise instructed. A follow-up appointment must be made or you must return to your primary care physician.
- 7) If you alter or forge prescriptions or sell or distribute pain medications, you will no longer receive treatment from any KOC physicians and you may be reported to the authorities.
- 8) Treatment with pain medication is at the discretion of the prescribing physician. You are not to adjust your amount without notifying the physician and this must be done during office hours. If the prescribing physician feels that you are not being honest about your usage of pain medication, or he/she feels like you are diverting your medication, KOC can discharge you from the clinic. You will be notified if this becomes necessary.

By signing this agreement, you acknowledge that you have read it and understand it and agree that you have been well-informed of the importance of following your physician's instructions regarding the use of narcotic pain medications.

_____ Date _____