

**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](http://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/<br>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/<br>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"/> Tonsilectomy	
<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.