Patient Registration

OrthoTennessee Care Center

MRN # _____

Physician _____

About The Patient

Full Name _____ (Last,) _____ (First) ____ (MI) _____ (Maiden Name) SSN _____

Birthdate _____ Sex _____

Street Address _____

City State Zip

Mailing Address _____

City State Zip

Race _____ Language _____ Ethnicity _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

VOLUNTARY

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Employer _____ Address _____

Occupation _____

Emergency Contact Name _____ Phone # _____

Your Spouse or Parent

Name: _____ Birthdate: _____

Address _____ Phone #: _____

Employer: _____ Emp. Phone #: _____

SSN (if financially responsible) _____

Insurance

Primary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Secondary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Reason For Visit

What body part are we seeing you for? _____ ☐ Right ☐ Left

This is (check one) ☐ Injury ☐ Onset of Pain Attourney Involved? ☐ Yes ☐ No

Date on injury or onset of pain _____

Type of accident: Auto ☐ Worker's Comp ☐ Other ☐

Referring Physician _____ Primary Physician (if different) _____

I. 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, and 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 Initials**: _____

II. 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 Initials**: _____

III. 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 Initials: _____

I have read and understand Sections I, II and III above.

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 name 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.

Parent/Legal Representative Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OrthoTennessee

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

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	
❑	❑	Anxiety	❑	❑	Hepatitis/Liver disease
❑	❑	Depression	❑	❑	Hypertension/High blood pressure
❑	❑	Bipolar	❑	❑	Myocardial Infarction/Heart attack
❑	❑	Arthritis	❑	❑	Osteoporosis
❑	❑	Asthma	❑	❑	Peptic ulcer disease
❑	❑	Cancer	❑	❑	Renal disease/Kidney disease
❑	❑	Congestive heart failure	❑	❑	Rheumatoid Arthritis
❑	❑	COPD/Emphysema	❑	❑	Seizures
❑	❑	Coronary artery disease/Heart Disease	❑	❑	Sleep apnea
❑	❑	Deep venous thrombosis/Blood clots	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Thyroid disease
❑	❑	Elevated lipids/High Cholesterol	❑	❑	HIV /Aids
❑	❑	Gout	❑	❑	Pulmonary embolus/Blood clots in lung

❑ Other illnesses currently or chronically treated_____

Past Surgical History - Have you had any of the following surgeries?

❑ **None**

❑ ACL repair __right __left
❑ Angioplasty
❑ Appendectomy
❑ Arthroscopy
❑ Back surgery
❑ Neck surgery
❑ Blood transfusion
❑ CABG/Coronary artery bypass
❑ Cardiac pacemaker
❑ Cardiac valve replacement
❑ Cholecystectomy/gall bladder
❑ Gastric bypass
❑ Hernia repair
❑ Hip replacement __right __left
❑ Knee replacement __right __left
❑ Meniscus surgery/Knee cartilage __right __left
❑ ORIF/Fracture surgery - body part_____
❑ Rotator cuff repair __right __left
❑ Thyroidectomy
❑ Tonsilectomy
❑ Hysterectomy

❑ Other surgery _____

Social History

Do you use tobacco? ❑ Yes ❑ No Amount _____

If no, ❑ never used tobacco ❑ former tobacco user

Do you use alcohol? ❑ Yes ❑ No Amount _____

Family History

Has anybody in your family had any of these conditions?

Blood disorder ❑ Yes ❑ No Family Member_____
Heart disease ❑ Yes ❑ No Family Member_____
Stroke ❑ Yes ❑ No Family Member_____
Cancer ❑ Yes ❑ No Family Member_____
Diabetes ❑ Yes ❑ No Family Member_____

Do you have sleep apnea?	❑ Yes	❑ No
Are you on blood thinners?	❑ Yes	❑ No
Are you pregnant?	❑ Yes	❑ No
Do you have a latex allergy?	❑ Yes	❑ No
Do you have metal allergy?	❑ Yes	❑ No

Immunizations

Have you had a Flu Vaccine in the last 12 mo.? ❑ Yes ❑ No Date _____

Have you had a Pneumonia Vaccine? ❑ Yes ❑ No Date _____

Allergies - List all drugs to which you are allergic:

_____
_____
_____

Type of reaction - Example: Skin rash, Nausea, etc.

_____
_____
_____

❑ **No known allergies**

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

_____
_____
_____
_____

❑ **I am not taking any medications at this time.**

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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	
❑	❑	Fever
❑	❑	Weight gain
❑	❑	Weight loss

HEAD, EYES, EARS, NOSE, THROAT ❑ Normal

NO	YES	
❑	❑	Headache
❑	❑	Hearing loss
❑	❑	Vision loss

RESPIRATORY ❑ Normal

NO	YES	
❑	❑	Cough
❑	❑	Dyspnea/Short of breath
❑	❑	Recent Infections
❑	❑	Wheezing

CARDIOVASCULAR ❑ Normal

NO	YES	
❑	❑	Chest pain
❑	❑	Irregular heartbeat/ palpitations
❑	❑	Poor circulation

GASTROINTESTINAL ❑ Normal

NO	YES	
❑	❑	Abdominal pain
❑	❑	Diarrhea
❑	❑	Vomiting
❑	❑	Reflux

GENITOURINARY ❑ Normal

NO	YES	
❑	❑	Dysuria/painful urination
❑	❑	Hematuria/Bloody urine
❑	❑	Urinary retention/ unable to urinate
❑	❑	Frequent bladder infections

NEUROROLOGICAL ❑ Normal

NO	YES	
❑	❑	Numbness in extremities

PSYCHIATRIC ❑ Normal

NO	YES	
❑	❑	Anxiety
❑	❑	Bipolar
❑	❑	Depression
❑	❑	Claustrophobia

SKIN ❑ Normal

NO	YES	
❑	❑	Rash
❑	❑	Skin infection
❑	❑	Sores that do not heal

MUSCULOSKELETAL

❑ Negative, except today's complaint

HEMATOLOGIC ❑ Normal

NO	YES	
❑	❑	Bleeding disorders

IMMUNOLOGICAL ❑ Normal

NO	YES	
❑	❑	Food allergies
❑	❑	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:**_____

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 physicians instructions regarding the use of narcotic pain medications.

_____ _____

SIGNATURE DATE