Woods Mill Orthopedics Registration Form ◯ **New Patient** ◯ **Update** Date: _____

Last Name, First Name, Middle Initial: _____

Street Name: _____

City, State, Zip Code: _____

◯Home Phone: _____ ◯Cell Phone: _____ ◯Work Phone: _____

Email Address: _____ ◯ Male ◯ Female ◯ Single ◯ Married ◯ Divorced

Race: _____ Ethnicity: _____ Language if other than English: _____

Date of Birth: _____ Age: _____Social Security Number: _____

Employer Name: _____

Who is responsible for payment: _____

Guarantors Address: _____

Guarantors City, State, Zip Code: _____

Who referred you to our office? _____ Primary Care Physician: _____

Is this a job related injury? ◯Yes ◯No Have you reported this injury? ◯Yes ◯No DOI: _____

Primary Insurance Name:

_____

Subscribers Name _____ Subscribers Date of Birth: _____

ID Number: _____Group Number: _____

Secondary Insurance Name:

_____

Subscribers Name _____ Subscribers Date of Birth: _____

ID Number: _____Group Number: _____

Patient Name:_____ Ht: _____ Wt:_____

Referred By: _____ Specialty MD's_____

REASON FOR VISIT: _____

INJURY (Date) _____ Where did it happen_____ How did it happen_____

PAIN (Type-sharp/dull etc) _____ How long _____ Severity (1-10) _____

What makes it better_____ What makes it worse_____

Other symptoms_____ Which is your dominant hand_____

Work status_____ Occupation_____ Work injury (yes/no) _____

Do you have current X-ray/MRI or other test: Date: _____ Location_____

MEDICATIONS: None_____ List: _____ _____ _____

_____ _____ _____ _____ _____

VACCINATIONS: Have you received: Flu vaccine _____ Date: _____ Pneumonia vaccine _____ Date: _____

MEDICAL HISTORY: NO MEDICAL PROBLEMS_____ Diabetes _____ Insulin _____ Heart disease _____

High blood pressure _____ High cholesterol _____ Heart attack _____ Congestive Heart Failure _____ Stroke _____

Arrhythmia/Afib _____ Blood Clots _____ Bleeding Problems _____ Lung disease _____ Asthma _____

Kidney Disease/stone _____ Reflux/indigestion _____ Ulcers _____ Irritable bowel/Crohn's _____ Hiatal hernia _____

Thyroid disease _____ Liver Problems/Cirrhosis _____ Urologic problems _____ Gout_____

Rheumatoid arthritis_____ Cancer(type) _____ Depression _____

ALLERGIES: None_____ List: _____

PREVIOUS SURGERY: None_____ List with Date: _____ _____ _____

_____ _____ _____ _____ _____

FAMILY HISTORY: Alive (A) Deceased (D) (Answer using A or D)

Father: _____ Age_____ Medical Problems: _____

Mother: _____Age_____ Medical Problems: _____

Children: # Sons_____ Daughters_____ Medical Problems:_____

SOCIAL HISTORY:

Do you smoke (Y/N) If yes: # per day _____ How many years _____ Do you want to quit _____

Do you drink alcohol (Y/N) If yes: # per day/week/month _____ Other substance use_____

Marital status _____ Education: Highest Level _____

REVIEW OF SYSTEMS: (Please mark those that apply) Good General Health_____

Recent Weight change_____ Fever_____ Glasses/contacts _____ Hearing problems _____

Wheezing _____ Shortness of Breath_____ Chest pain _____ Blood in stool _____ Anemia _____

Urinary problems _____ Skin ulcer _____

MD Init: _____

Date: _____

SIGNATURE/DATE: _____

The completion of this form is required by Medicare

Patient Name: _____ Date of Birth: _____

1. Do you receive Veteran's Benefits? ◯ Yes ◯ No
2. Are you receiving benefits under the Black Lung Program? ◯ Yes ◯ No
3. Is your treatment due to a work related accident/condition? ◯ Yes ◯ No
4. Is your treatment due to an automobile accident? ◯ Yes ◯ No
5. Do you intend to file a liability suit or is litigation pending? ◯ Yes ◯ No
6. Are you entitled to Medicare base on:
   - ◯ Age (65 & over) go to question 7
   - ◯ Disability-go to question 7
   - ◯ End Stage Renal Disease? If you have group health insurance what is the name? _____
7. Are you currently employed? ◯ Yes ◯ No
8. Year of retirement: _____
9. Is your spouse currently employed? ◯ Yes ◯ No
10. Do you have coverage based on your spouse's employment? ◯ Yes ◯ No
11. Are you receiving any of the following?
    - Skilled Nursing Services? ◯ Yes ◯ No
    - Hospice Care? ◯ Yes ◯ No
    - Home Health Care? ◯ Yes ◯ No
    - If yes to any of the above we require the Company Name: _____
      Address: _____
      City, State, Zip: _____

Woods Mill Orthopedics, Ltd. Is pleased to provide you with information regarding cost, quality and ease of access so you can make an informed decision. The physician-owned services are priced 10-50% less than some of the competing services listed below. In addition to providing a cost advantage, we feel that the service providers to which we refer you deliver high quality services that are easy to access and convenient.

The Federal Government (Patient Protection and Affordable Healthcare Act, Sections 6409 & 6003, dated March 23, 2010) mandates we provide information on facilities other than those owned by our physicians. You have the right to choose your facility. If you would like to receive services at another facility, we will be happy to provide you with a referral. Some examples of facilities in the area are St. Luke's Hospital and St. Luke's Center for Diagnostic Imaging. Some our physician's maintain ownership at Signature MRI.

Patient Signature: _____ Date: _____

Who may we discuss your medical care with?

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

May we leave voice mail messages on your telephone? ◯ Yes ◯ No
May we text your cell phone? ◯ Yes ◯ No Cell Phone#: _____
May we call your cell phone regarding any billing issues? ◯ Yes ◯ No

Who is your Primary Care Physician: _____

Preferred Pharmacy Name: _____ Pharmacy Phone No_____

Authorization to Release Information:
I hereby authorize Woods Mill Orthopedics, Ltd to release any information acquired in the course of my examination or treatment (including any billing information) to individuals listed above.

Medicare Lifetime & Medigap Signature on File:
I request that payment of authorized Medicare, Medigap and all other insurance company benefits be made on my behalf to Woods Mill Orthopedics, Ltd, for any services furnished to me by the provider. I authorize any holder of medical information about me to be released to my health insurance company or the Health Care Financing Administration and its agent's needed to determine these benefits or benefits payable for related services.

Advanced Beneficiary Notice of Medicare Non-Coverage and Terms of any other insurances:
I understand that when accepting any treatment or durable medical goods from my provider the charges will be billed to my insurance company or Medicare for an official decision on payment, which is sent to me on a Summary Notice. I understand that if my insurance or Medicare doesn't pay, I am responsible for payment, but I can appeal to my insurance company or Medicare by following the directions on the Summary Notice. If my insurance or Medicare does pay Woods Mill Orthopedics, Ltd will refund any payments I made to you, less co-pays or deductibles. I understand it is my responsibility to know the terms of my insurance plan. If I do not present my current insurance card or any required referral numbers or forms from my primary care physician for specialty care at the time of every visit I am choosing to go outside my plan. Additionally, there may be charges that are not covered by my insurance company. I understand I am responsible for all charges incurred by me, and I further agree to prompt payment of any services billed in these situations.

I authorize payment of medical benefits provided by my medical insurance described on a standard health form to Woods Mill Orthopedics, LTD for services provided during my care and treatment as described on the standard health care form information necessary to process claims. I understand that I am financially responsible for the charges covered by this authorization, and I will be responsible for any collection fees or cost associated with collections. I understand I may request a copy of and/or review the Notice of Privacy Practices at any time.

I give the physicians of Woods Mill Orthopedics, LTD permission to view my prescription history from external sources including pharmacies, other physicians, hospitals and my health insurance.

Signature:_____ Date:_____