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: _________________________________◯ Male ◯ Female ◯ Single ◯ Married ◯ Divorced

Race: _______________ Ethnicity: _________________ Language if other than English: __________

Date of Birth: __________________ Age: ________Social Security Number: ____________________

Employer Name: ____

Guarantor if patient is under 18: ______________________________ Phone: ___________________

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 SELF or Name ____________________________ Subscribers Date of Birth: _______________

Secondary Insurance Name: ____

Subscribers Name ____________________________ Subscribers Date of Birth: __________________

Insurance cards are required, please give card(s) to front desk for scanning and eligibility check.

Medicare Patients:
Are you currently receiving services for: Hospice Care ◯Yes ◯No
Skilled Nursing ◯Yes ◯No If yes, name of facility: ______________________________________

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 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 of our physicians maintain ownership at Greater Missouri Imaging, City Place Surgery Center, and St. Luke's Surgical Center of Chesterfield.

Patient Signature: ____ Date: ____________________

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 _____ Gout _____ Afib _____

Arrhythmia _______ High blood pressure _______ High cholesterol _______ Heart attack _____ Congestive Heart Failure ______

Stroke _____ Blood Clots _____ Kidney Disease _____ Reflux _____ Depression _____ Irritable bowel _____ Parkinson's ______

Bleeding Problems ______ Thyroid disease ______ Urologic problems ______ Rheumatoid arthritis ______ Neuropathy ________

Alzheimer's/Dementia _____ Liver Problem (type) __________ Lung disease (type) __________

Ulcer (type) __________ Cancer (type) __________ Autoimmune disease (type) __________

Other ____

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 abuse __________

Marital status __________ Education: Highest Level ______________________________

REVIEW OF SYSTEMS: (Please mark those that apply) Good General Health________ Fever _____

Recent Weight change______ Glasses/contacts _____ Hearing problems _____ Wheezing _____ Skin ulcer _____

Shortness of Breath______ Chest pain ______ Blood in stool _____ Anemia ______ Urinary problems ______

MD init: ____

Date: ______

SIGNATURE/DATE: ____

HHF-2021

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:______________________