NOLO ORTHO

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NEW PATIENT REGISTRATION

1

Patient Name: _____ **DOB:** ___/___/_____ **SSN:** _____-_____-_____

Mailing Address: _____

City: _____ **ST:** _____ **Zip**: _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____

Please Leave Messages On My: ☐ Home ☐ Cell ☐ Work

email Address: _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer: _____ **Occupation:** _____

***Race:** ☐ American Indian Or Alaska Native ☐ Asian ☐ Native Hawaiian Or Other Pacific Islander
☐ Black Or African American ☐ White ☐ Hispanic ☐ Other Race _____

***Ethnicity:** ☐ Hispanic ☐ Non Hispanic ☐ Refuse To Report

Language: _____

Emergency Contact Name: _____ **Relation:** _____

Phone: (_____) _____ **Living Will?** ☐ **Yes** ☐ **No**

Power Of Attorney? ☐ **Yes** ☐ **No**

**Government requires this information to protect patients against discrimination*

Person Responsible For Bill ***(If Different From Patient):***

Relation: _____ **Name** _____ **DOB:** ___/___/_____ **SSN:** _____-_____-_____

Address *(If Not Same As Above):* _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____

2

PRIMARY INSURANCE COMPANY: _____

Policy Holder: _____ **DOB:** ___/___/_____

SECONDARY INSURANCE COMPANY: _____

Policy Holder: _____ **DOB:** ___/___/_____

PRIMARY CARE PROVIDER: _____ **Office Phone:** (_____) _____

REFERRING PROVIDER: _____ **Office Phone:** (_____) _____

Who may we thank for your visit today: _____

MEDICAL HISTORY

Patient Name: _____ **Primary Care Physician:** _____

DOB: ____/____/_____ **Gender:** _____ **Age**_____

PAIN HISTORY BACKGROUND

3

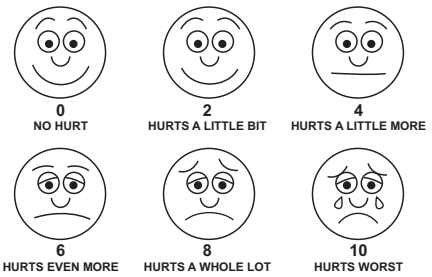
What is your main reason for visit?

Which side is your pain located on?
☐ **Right** ☐ **Left** ☐ **Both**

How long has this pain been present? _____ **Days** _____ **Weeks** _____ **Months** _____ **Years**

How often is the pain present? ***(please check)***
☐ Constant
☐ Frequent (several times/hour)
☐ Sporadic (several times/day)
☐ Occasional (several times/week)
☐ Rare (several times/month)

Rank your Pain on scale of 1 to 10
(worst pain): _____



What words best describe how the pain feels? ***(please check)*** ☐ Sharp ☐ Burning
☐ Shooting ☐ Stabbing ☐ Deep ☐ Aching ☐ Dull ☐ Tingling ☐ Throbbing
☐ Pressure ☐ Other: _____

What makes your pain *better*? *(please check)*
☐ Heat ☐ Cold ☐ Medication ☐ Exercise

What makes your pain *worse*? *(please check)* ☐ Heat ☐ Cold ☐ Walking ☐ Sitting
☐ Standing ☐ Lying ☐ Stress ☐ Bending/Twisting ☐ Coughing/Sneezing
☐ Standing from Sitting

4

Have you tried physical therapy?	☐ **Yes**	☐ **No**	**Helpful?**	☐ **Yes**	☐ **No**	**Where?**
Have you tried chiropractic treatments?	☐ **Yes**	☐ **No**	**Helpful?**	☐ **Yes**	☐ **No**	**Where?**
Have you tried a brace or support?	☐ **Yes**	☐ **No**	**Helpful?**	☐ **Yes**	☐ **No**	**Where?**
Are you taking prednisone or cortisone pills?	☐ **Yes**	☐ **No**	**Helpful?**	☐ **Yes**	☐ **No**	**Where?**
Have you had a cortisone injection?	☐ **Yes**	☐ **No**	**Helpful?**	☐ **Yes**	☐ **No**	**Where?**

5

Work related injury	**Date:**
Motor vehicle accident	**Date:**
Fall or other trauma	**Date:**
Following surgery	**Date:**
Following illness	**Date:**
Unknown reason	**Date:**

How did your main pain complaint begin? *(please give details):*

_____

_____

_____

Other:

TREATMENT HISTORY

Have you had a **RADIOLOGIC IMAGING** for your current pain complaint? ☐ **Yes** ☐ **No** *(please bring images to initial appointment)*

6

STUDY TYPE	BODY PART IMAGED	DATE OF STUDY	WHERE STUDY WAS PERFORMED
X-Ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other:			

Have you had an Electromyography or EMG test to evaluate nerve function? ☐ **Yes** ☐ **No**

Are you currently being treated by a pain management physician or clinic? ☐ **Yes** ☐ **No**

Patient Name: _____ DOB: ____/____/_____

PAST MEDICAL HISTORY ☐ N/A *(not applicable)*

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☐ Abnormal Heart Beat	☐ Depression	☐ Heart Attack	☐ Rheumatoid Arthritis
☐ Stomach Ulcer or GI Bleed	☐ Anxiety	☐ Emphysema/COPD	☐ Osteoarthritis
☐ Heartburn/Acid Reflux (GERD)	☐ Insomnia	☐ Cancer	☐ Pacemaker
☐ Diabetes	☐ Seizures	☐ Stroke	☐ Stent
☐ Liver Disease	☐ Fibromyalgia	☐ Asthma	☐ Multiple Sclerosis (MS)
☐ Kidney Disease	☐ Migraine Headaches	☐ Hypothyroid/Hyperthyroid	☐ Irritable Bowel
☐ Bleeding Disorder	☐ Psychiatric Conditions	☐ High Blood Pressure	☐ HIV/Aids
☐ Sleep Apnea	☐ Alcoholism	☐ High Cholesterol	☐ Vascular Disease
		☐ Hepatitis	☐ Broken Bones

PAST SURGICAL HISTORY ☐ N/A *(not applicable)* *Please list any surgical procedures you have had in the past.*

8

SURGERY	DATE (MONTH/YEAR)	SURGEON

CURRENT MEDICATIONS

Preferred Pharmacy:_____ Location:_____ Phone: _____

9

ALLERGIES

10

Do you have any known drug allergies? ☐ Yes ☐ No	Are you allergic to IV contrast dye? ☐ Yes ☐ No
If yes, please list your allergies:	Are you allergic to local anesthetics? ☐ Yes ☐ No
	Are you allergic to latex? ☐ Yes ☐ No

HEIGHT AND WEIGHT

11

Height:	Weight:

FAMILY MEDICAL HISTORY

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Father	☐ Diabetes	☐ Heart Disease	☐ Bleeding Disorder	☐ Stroke	☐ Cancer	☐ High Blood Pressure
Mother	☐ Diabetes	☐ Heart Disease	☐ Bleeding Disorder	☐ Stroke	☐ Cancer	☐ High Blood Pressure
Brother	☐ Diabetes	☐ Heart Disease	☐ Bleeding Disorder	☐ Stroke	☐ Cancer	☐ High Blood Pressure
Sister	☐ Diabetes	☐ Heart Disease	☐ Bleeding Disorder	☐ Stroke	☐ Cancer	☐ High Blood Pressure

SOCIAL HISTORY

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What is your marital status?	☐ Single	☐ Married	☐ Divorced	☐ Widowed	
Occupation?	☐ Full-time	☐ Part-time	☐ Retired	☐ Student	☐ Disabled
Do you use tobacco?	☐ Non-Smoker	☐ Current Smoker ☐ Cigarettes/Cigars _____ packs/day		☐ Former Smoker ☐ Date Quit: _____	☐ Other
Do you use alcohol?	☐ Never	☐ Rarely	☐ Socially	☐ Regularly, _____ drinks/day	

FINANCIAL POLICY

FINANCIAL AGREEMENT/RESPONSIBILITY

I acknowledge financial responsibility for services provided by NoloOrtho. I understand that the clinic wlll file my Insurance as a courtesy and that I am responsible for any amounts including but not limited to: co-payments, co-insurance, deductibles, FMLA/ Disability paperwork, copies of X-rays and/or medical records. I understand that co-pays and prior balances are due at time of service. Deductibles and co-insurance carries made on my behalf will be directed to NoloOrtho for services provided.

Signed: _____ **Date:** _____

CONSENT OF TREATMENT/PAYMENT/HIPAA CONSENT

I authorize NoloOrtho physician and staff to provide medical treatment as needed. I authorize the order and use X-rays, Injections, casting and/or diagnostic tests to diagnose and treat my illness or injuries. I hereby consent to NoloOrtho to use or disclose, for the purpose of carrying out treatment, payment, and/or healthcare operations at any time by giving a written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health Information.

Signed: _____ **Date:** _____

CONSENT OF COMMUNICATION METHOD

I acknowledge and agree that NoloOrtho and any affiliates or vendor thereof, Including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided and any other telephone number associated with my account, including wireless and/or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as ATDS (Automated Telephone Dialing System) or pre-recorded message, I also agree that I will notify NoloOrtho if I have given up ownership or control of any such telephone numbers.

Signed: _____ **Date:** _____

ePRESCRIBING

A patient portal Is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. ePrescriblng is defined as a physician's ability to electronically send an accurate, error free and understandable prescription to a pharmacy from the point of care. ePrescrlblng greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included In an ePrescribing program. These include:

- **Formulary and benefit transactions** - Gives the prescriber Information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient Is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that NoloOrtho can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signed: _____ **Date:** _____

I have received a copy of the Notice of Privacy Practices of NoloOrtho.

Signed: _____ **Date:** _____