ATHLETIC ORTHOPEDICS & KNEE CENTER
FOOT • ANKLE • HAND • PAIN • SHOULDER • SPINE

Patient Registration Form

Name: _____

Date: M M / D D / Y Y Y Y

PATIENT INFORMATION

Last Name	First	MI	Sex ❑ Male ❑ Female
Birth Date M M / D D / Y Y Y Y	Age	SSN - -	Drivers License
Address	City	State	Zip
Home Phone #	Work #	Cell #	
Email		Preferred Method of Contact	
Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic Partner			
Spouse's Name		Phone #	
Emergency Contact Name		Phone #	

INSURANCE

Primary Insurance	Policy #	Type of Network	Group #
Address	City	State	Zip
Insured's Name		Sex ❑ Male ❑ Female	
Insured's Employer		Phone #	
Birth Date M M / D D / Y Y Y Y	SSN - -	Relationship to Patient ❑ Self ❑ Spouse ❑ Dependent	
Insurance Address	City	State	Zip
Person Responsible for Payment	Relationship to Patient	Phone #	
Address	City	State	Zip

REFERRED BY

Physician	Magazine/Newspaper	Company
Friend	Health Fair/Community Event	Other

PHARMACY

Pharmacy Name		Phone #	
Address	City	State	Zip

PRIMARY CARE

Primary Care Physician Name		Phone #	
Address	City	State	Zip

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Patient Pain Form

Name: _____

Date: M M / D D / Y Y Y Y

TODAY'S VISIT

What is the reason for your visit today?

LOCATION OF PAIN

Ankle	❑ L	❑ R	Calf	❑ L	❑ R	Cervical Spine	❑ L	❑ R	Chest/Sternum	❑ L	❑ R
Coccyx	❑ L	❑ R	Elbow	❑ L	❑ R	Finger	❑ L	❑ R	Forearm	❑ L	❑ R
Foot	❑ L	❑ R	Hand	❑ L	❑ R	Hip	❑ L	❑ R	Knee	❑ L	❑ R
Lower Back	❑ L	❑ R	Lower Leg	❑ L	❑ R	Ribs	❑ L	❑ R	Sacrum	❑ L	❑ R
Shoulder	❑ L	❑ R	Thigh	❑ L	❑ R	Toes	❑ L	❑ R	Upper Arm	❑ L	❑ R
Upper Back	❑ L	❑ R	Wrist	❑ L	❑ R	Other: _____				❑ L	❑ R

❑ Bilateral (Both Sides) ❑ Anterior (Front) ❑ Posterior (Back) ❑ Medial (Inner) ❑ Lateral (Outer)

TYPE

❑ Pain ❑ Stiffness
❑ Fracture ❑ Injection
❑ Post-Operative ❑ Follow-up

SEVERITY

❑ No Pain ❑ Mild ❑ Moderate ❑ Severe

Pain Level (circle one): NONE 0 1 2 3 4 5 6 7 8 9 EXTREME 10

DURATION

Date of Onset: _____

_____ Days _____ Weeks

_____ Months _____ Years

CONTEXT

❑ Cannot Identify ❑ Fall
❑ Bending ❑ Lifting
❑ Twisting ❑ Sports Injury
❑ Work Injury ❑ Car Accident
❑ Assault ❑ Overuse
❑ Laceration ❑ Heard a Pop
❑ Other: _____

TIMING

❑ Cannot Identify ❑ Acute
❑ Chronic ❑ Abrupt
❑ Gradual ❑ Morning
❑ Daytime ❑ Nighttime
❑ Recurrent ❑ Rare
❑ Occasional ❑ Continuous
❑ Intermittent Episodes Lasting: _____

QUALITY

❑ Aching ❑ Burning
❑ Gnawing ❑ Stabbing
❑ Throbbing ❑ Sharp
❑ Dull ❑ Superficial
❑ Deep ❑ Occasional
❑ Frequent ❑ Constant
❑ Worsening ❑ Improving
❑ No Change

ASSOCIATED SYMPTOMS

❑ Weakness ❑ Numbness
❑ Tingling ❑ Swelling
❑ Redness ❑ Warmth
❑ Bruising ❑ Catching/Locking
❑ Popping/Clicking ❑ Buckling
❑ Grinding ❑ Instability
❑ Drainage ❑ Fever
❑ Weight Loss ❑ Radiating Pain
❑ Change in Bowel/Bladder Habits
❑ Other: _____

ALLEVIATING FACTORS

❑ Nothing Helps ❑ Ice
❑ Rest ❑ Elevation
❑ Exercise ❑ Stretching
❑ PT/OT ❑ NSAIDs
❑ Orthotics ❑ Brace
❑ Previous Surgery ❑ Sling
❑ Limited Weight-bearing
❑ Chiropractic Care ❑ Narcotics
❑ Epidural Steroid Injection
❑ Over-the-counter Medication
❑ Cortisone Injection
❑ Viscosupplementation Injection
❑ Other: _____

AGGREVATING FACTORS

❑ Cannot Identify ❑ Lifting
❑ Carrying ❑ Twisting
❑ Pushing/Pulling ❑ Gripping
❑ Grasping ❑ Squeezing
❑ Throwing ❑ Range of Motion
❑ Weight-bearing ❑ Exercise
❑ Previous Surgery ❑ Computer Use
❑ Changing Clothes ❑ Getting Out of Bed
❑ Going from Sit to Stand
❑ Morning ❑ Daytime
❑ Nighttime ❑ Cold Weather
❑ Damp Weather ❑ Driving
❑ Other: _____

PRIOR RELATED INCIDENCES

Prior Related Surgery ❑ None ❑ Yes	Procedure Type	Procedure Date M M / D D / Y Y Y Y
Prior Imaging (Past 3 Months) ❑ None ❑ Yes	Imaging Type ❑ X-Ray ❑ MRI ❑ Other: _____	Imaging Date M M / D D / Y Y Y Y
Previous Injections ❑ None ❑ Yes	Injection Type	Injection Date M M / D D / Y Y Y Y
❑ Injections Did Not Help ❑ Injections Helped a Little ❑ Injections Helped Temporarily		❑ Injections Helped Significantly
Previous Therapy ❑ None ❑ Yes	Therapy Type	Therapy Date M M / D D / Y Y Y Y
❑ Therapy Did Not Help ❑ Therapy Helped a Little ❑ Therapy Helped Temporarily		❑ Therapy Helped Significantly

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Patient Symptoms & History Form

Name: _____

Date: M M / D D / Y Y Y Y

REVIEW OF SYMPTOMS

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

General:	❑ Fever ❑ Chills ❑ Night Sweats ❑ Unexpected Weight Loss or Gain ❑ Fatigue ❑ Loss of Appetite
Skin:	❑ Rash ❑ Skin Lesions ❑ Abnormal Mole ❑ Jaundice ❑ Itching
Eyes:	❑ Eye Pain ❑ Double Vision ❑ Severe Redness
Ears:	❑ Ear Pain ❑ Difficulty Hearing ❑ Ringing in Ears ❑ Dizziness
Nose:	❑ Runny Nose ❑ Nasal Congestion ❑ Frequent Nose Bleeds ❑ Nasal/Sinus Pressure
Mouth/Throat:	❑ Sore Throat ❑ Difficulty Swallowing ❑ Bleeding Gums ❑ Sores in Mouth ❑ Tooth Pain ❑ Hoarseness
Chest/Heart:	❑ Chest Pain ❑ Racing/Pounding Heart ❑ Palpitations ❑ Shortness of Breath when Lying Down ❑ Lower Leg Swelling ❑ Fainting ❑ Calf Pain with Walking
Neck:	❑ Pain ❑ Swelling
Respiratory:	❑ Shortness of Breath ❑ Cough ❑ Wheezing ❑ Coughing up Blood
Stomach:	❑ Nausea/Vomiting ❑ Heartburn ❑ Abdominal Pain ❑ Vomiting Blood
Bowels:	❑ Diarrhea ❑ Constipation ❑ Black/Tarry/Bloody Stools ❑ Unusual Change in Stool Size/Shape/Color
Urinary Tract:	❑ Blood in Urine ❑ Increased Urination ❑ Difficulty Urinating ❑ Pain when Urinating ❑ Waking to Urinate
Musculoskeletal:	❑ Joint Pain ❑ Muscle Weakness ❑ Back Pain ❑ Swelling in Extremities ❑ Limited Range of Motion in Joints
Neurological:	❑ Seizures ❑ Problems with Coordination ❑ Memory/Sensory Issues ❑ Loss of Consciousness ❑ Numbness ❑ Weakness ❑ Tingling ❑ Dizziness ❑ Severe Headache
Endocrine:	❑ Fatigue ❑ Increased Thirst ❑ Cold Intolerance ❑ Heat Intolerance
Hematologic:	❑ Frequent Nose Bleeds ❑ Easy Bruising ❑ Easy Bleeding ❑ Swollen Hands/Feet ❑ Swollen Glands
Immunologic:	❑ Recurrent Infections ❑ Sneezing ❑ Itchy Eyes
Psychiatric:	❑ Depression/Anxiety ❑ Mood Swings ❑ Emotional Changes ❑ Substance Abuse ❑ Suicide Attempts

❑ No to all

PAST MEDICAL HISTORY

❑ Anemia
❑ Anxiety Disorder
❑ Arthritis
❑ Asthma
❑ Bleeding Disorder
❑ Blood Clot
❑ Cancer
❑ Coronary Artery Disease
❑ Depression
❑ Diabetes
❑ GERD/Reflux
❑ Gastrointestinal Ulcers
❑ Gout
❑ HIV or AIDS
❑ Heart Attack
❑ Heart Disease
❑ Heart Problems
❑ Hepatitis
❑ Hernia
❑ Hypertension
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Kidney Disease
❑ Leg or Foot Ulcers
❑ Liver Disease
❑ Lung Disease
❑ Migraines
❑ Osteoporosis
❑ Pacemaker
❑ Peripheral Vascular Disease
❑ Pulmonary Embolism
❑ Rheumatoid Arthritis
❑ Seizures/Epilepsy
❑ Stroke
❑ Tuberculosis
❑ Other: _____

❑ No to all

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Patient General Health Form

Name: _____

Date: M M / D D / Y Y Y Y

GENERAL INFO

Last Name	First	MI	Birth Date M M / D D / Y Y Y Y

Height	Weight	Are You Pregnant?	Living Arrangement
		❑ No ❑ Yes: _____ months	❑ Alone ❑ With Others

Employer	Occupation	School/Team	Team/Sport

Exercise Level	Hand Dominance	Sporting Activities
❑ None ❑ Occasional ❑ Moderate ❑ Heavy		

Use of tobacco products	Illicit Drug Use
❑ Never ❑ In the Past ❑ Currently; _____packs/day	❑ No ❑ Yes; Type(s):_____

Alcohol Consumption
❑ Never ❑ Occasional ❑ Moderate ❑ Heavy _____drinks/week

ALLERGIES

Are you allergic to any medications? ❑ No ❑ Yes

Medication	Reaction	Medication	Reaction
Medication	Reaction	Medication	Reaction

PREVIOUS SURGERY

Please list any surgeries or hospitalizations you have had in the past ❑ None

Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year

CURRENT MEDICATIONS

Please list all current medications ❑ None

Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed

FAMILY HISTORY

Family Member	Health Issue	❑ Deceased
Family Member	Health Issue	❑ Deceased
Family Member	Health Issue	❑ Deceased

SIGNATURE

I certify that the facts contained on this form are true and complete to the best of my knowledge.

_____ Signature

_____ Printed Name

_____ Date

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Patient Financial Responsibility Form

Date: M M / D D / Y Y Y Y

FINANCIAL RESPONSIBILITY

I understand that payment in full is expected at the time services are rendered. If prior arrangements have been made, Athletic Orthopedics and Knee Center (AOKC) may bill my insurance company for the estimated portion. This is a courtesy to me and I am responsible for the total payment of all charges regardless of insurance coverage.

Since some insurance carriers are unnecessarily delaying payment of claims, I may be called upon for payment if Athletic Orthopedics and Knee Center has not received payment within 60 days of billing. If Athletic Orthopedics and Knee Center receives any subsequent payment from my insurance company, then a credit balance will be promptly refunded to me.

I understand that my insurance is a contract between me, my employer and the insurance company. Athletic Orthopedics and Knee Center is not a party to that contract and cannot be responsible for negotiating payment.

I hereby authorize my insurance benefits to be paid directly to Athletic Orthopedics and Knee Center realizing I am responsible for payment as stated above.

I hereby authorize Athletic Orthopedics and Knee Center to release medical information pertaining to my claim to my insurance company, third party payor and/or my attorney. There is a fee for copying medical records. Unless otherwise specified, I authorize AOKC to access a national pharmacy database for my medication history.

Signature _____ Date _____

MEDICAL RELEASE

I hereby authorize Athletic Orthopedics and Knee Center to release medical information pertaining to my claim to my insurance company, third party payor and/or my attorney. There is a fee for copying medical records.

Signature _____ Date _____

PRIVACY PRACTICE

I have read the Privacy Practice documented by Athletic Orthopedics and Knee Center.

Signature _____ Date _____

Print

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