Litchfield County Orthopedic & Spine, PC

Patient Registration

Name: ____
First Middle Last

Street Address:____

City:______________________**State:** ____________**Zip:**______________

Mailing Address if different from above:______________________________

Home Phone:(____) ____________________ **Cell Phone:**(_____) ____________________

Work Phone:(____) ____________Ext ________ **May we contact you at work?** ____ Yes ____ No

E-mail Address: ____

Date of Birth: ______________________**Social Security #:**______________________
Month Day Year

Please Circle the following responses:

Sex: Male Female Transgender (MTF) Transgender (FTM)

Marital Status: Single Married Partnered Separated Divorced Widowed

Race: American Indian/Alaska Native Asian Black/African American White Other

Ethnicity: Hispanic/Latino Not Hispanic/Latino Prefer Not to Report

Emergency Contact: ____________________ **Phone:** (___) __________ **Relationship:** ______________

Preferred Pharmacy: ______________________ **Address:**______________________

Did your injury happen on the job? ____ Yes ____ No **If yes, date of injury?** ______________

Is this injury a result of a motor vehicle accident?_______Yes_____No If yes, date of accident ___________

Attorney's Firm & Name: ______________________ **Attorney's phone #:** ______________

Primary Care Physician's name:______________________**PCP's Phone:**______________

Who referred you here? ____

If you wish for a family member or friend to have access to your health information and/or discuss medical concerns on your behalf, please provide their name and date of birth as well as contact phone number:____

____

____

____

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PATIENT INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Subscriber:	Subscriber:
Date of Birth: SS#:	Date of Birth SS#:
Policy#:	Policy#:
Group#:	Group#:
Employer:	Employer:

COMPLETE THIS SECTION ONLY IF PATIENT IS A MINOR

Father/Guardian: Date of Birth:	Mother: Date of Birth:
Address:	Address:
SS#:	SS#:
Employer: Phone#	Employer: Phone#
Employer's Address:	Employer's Address:

By signing below, I authorize Litchfield County Orthopedic & Spine, PC (LCOS,PC) to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to LCOS,PC and I agree that a reproduced copy of this authorization will be as valid as the original.

I understand that any bills I incur at LCOS,PC are ultimately my responsibility. Although the staff at LCOS,PC attempts to verify all insurance plans and coverage, it is my responsibility to know whether my plan is in network or out of network, or whether certain services are covered by my plan. I am responsible for any co-pays and/or deductibles as described in the terms of my insurance. If my insurance company or Workers' Compensation carrier denies my claim or if my motor vehicle accident insurance benefit becomes exhausted or if my medical insurance term runs out during my treatment here, I will take responsibility for payment of any outstanding bills. I agree that I will be responsible for any collection agency or attorney fees incurred.

If my insurance is an HMO or managed care product, I understand that I will be responsible for obtaining the required referral that is necessary for me to receive treatment from LCOS,PC. If I fail to do so or if my treatment is beyond that which is authorized, I understand that I will be responsible for payment of such services not covered by my plan.

By signing below, I give consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing below I give consent for examination and the performance of any tests or procedures needed for the above minor patient.

Signed:______________________________ **Date:**______________________________

Patient or Guardian

Litchfield County Orthopedic & Spine, PC

History & Physical

Name:________________________ **Today's Date:**________________________

Primary Care Provider: ________________ **Referring Provider:** ________________

Date of Birth:________________________ **Height:**______**Weight:**____________

Hand Dominance: ____Right _____Left

Chief Complaint:

Why are you visiting the office today & when did symptoms start?____________________

____

On a scale of 1-10 (1 being the least, 10 being the worst) what is your pain level today? __________

Current problem is a result of: _______Car Accident _______Work Accident
Date of Accident:________________

_______Sports _______Home _______Other: (Explain)________________________

Quality of Pain: ___Sharp ___Dull ___Stabbing ___Throbbing ___Aching ___Burning

The Pain is: ___Constant ___Comes and Goes

Do you have: ___Swelling ___Cramping of legs ___Numbness/tingling ___Weakness
___ Loss of bowel or bladder control

What helps relieve: ___Rest ___Elevation ___Ice/Heat ___Exercise ___Bending forward

What makes worse: ___Standing ___Walking ___Lifting ___Exercise ___Lying down ___Kneeling ___Sitting
___Twisting ___Stairs ___Coughing

Since this problem has started, it is: ______Getting worse _______Getting better _______Unchanged

Have you ever been treated for this condition before? _______No _______Yes

By whom?________________________________ When?________________

What type of treatment did you have previously?________________________________

____

Have you had physical therapy for the above? _____No _______Yes
If yes, when did you start and what have the results been?________________________

____

Have you had anti-inflammatories? _____No _______Yes
If yes, which one(s) and how often? What have results been?____________________

____

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Have you had recent imaging (x-ray, MRI, CT Scan)? If so, where?______________________________

____

Any other treatment for the above? ______________________________

____

Review of Systems: Please check any type of symptom you are experiencing

GENERAL	X	**CARDIOVASCULAR**	X	**GENITOURINARY**	X
Fever		Chest Pain		Difficulty with urination	
Chills		Leg swelling		Painful urination	
Unplanned weight loss		Leg pain with walking		Increased frequency	
Other:		Leg pain at rest		Blood in urine	
RESPIRATORY		Palpitations		Loss of bladder control	
Difficulty breathing		Other:		Impotence	
Shortness of breath		**GASTROINTESTINAL**		Other:	
Other:		Abdominal pain		**NEUROLOGICAL**	
ENDOCRINE		Change in bowel habits		Loss of bowel/bladder control	
Cold intolerance		Nausea/Vomiting		Dizziness	
Increased thirst		Rectal bleeding		Headaches	
Increased urination		Other:		Numbness/tingling	
Hair changes		**PSYCHIATRIC**		Tremors	
Sexual Dysfunction		Anxiety		Other:	
Other:		Change in sleep patter		**HEMATOLOGY**	
MUSCULOSKELETAL		Depression		Bleeding tendency	
Decreased range of motion		Other:		Clotting tendency	
Joint pain		**ALLERGIES**		Other:	
Joint swelling		Asthma		**EARS/NOSE/THROAT**	
Joint stiffness		Eczema		Double vision	
Muscle wasting		Hives		Decreased hearing	
Muscle weakness		Other:		Ear ringing	
Other:				Other:	

Women only: Is it possible you are pregnant:____Yes _____No

Medications: ***Please list (let us know if you have a list, we are happy to copy it)***

Name Dose Frequency Reason for Medication

____

____

____

____

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Allergies to Medications:______________________________

____

Allergy to Latex: __________Yes __________No

Past Medical History: please check if you have been diagnosed with any of the following conditions

Condition		Condition		Condition	
Anemia		Emphysema/COPD		Pancreatitis	
Asthma/Bronchitis		Epilepsy		Pulmonary Embolism	
Atrial Fibrillation		Gastric Ulcer		Psychiatric Disorder	
Bladder Infection/UTI		Glaucoma		Reflux	
Bleeding Disorder		Gout		Rheumatoid Arthritis	
Bleeding Ulcer		Heart Arrhythmia		Sleep Apnea	
Blood in Stools		Heart Attack/MI		Stroke	
Cancer/Leukemia		Hepatitis		Thyroid Disorder	
Cellulitis		High Blood Pressure		Other:	
Coronary Artery Disease		HIV			
Deep Vein Thrombosis		Kidney Disease			
Diabetes Mellitus		Liver Disease			
Elevated Cholesterol		Osteoporosis			

Surgical History: ***Please list***

Surgery Performed Year Complications

____

____

____

____

____

____

____

____

Have you ever had general anesthesia? ________Yes ________No

Did you have any problems with anesthesia? ________Yes ________No

If Yes, describe:______________________________

____

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Family History:

	Alive	Deceased	Medical conditions, Cause of death
Father	_______	_______	________________________________
Mother	_______	_______	________________________________

Does any of your immediate family have any of the following conditions:

___Neck Pain ___Low Back Pain ___Osteoarthritis ___Rheumatoid Arthritis ___Cancer ___Diabetes

___Coronary Artery Disease ___Emphysema ___Heart Attack/MI ___Asthma ___Thyroid Disorder

Other:____

Social History:

Occupation & Employer____

Or ____Unemployed ____Self-Employed ____Retired ____Disabled ____Student

Do you have children? ____Yes ____No If yes, how many? ___________

Who do you live with? ____Alone____ Spouse/Partner ____Family ____Friend(s)____Group Setting

Tobacco Use:

_______Current Smoker: ___Heavy (20+ cigs/day) __Moderate (10-19 cigs/day)___ Light (1-9 cigs/day)

_______Former Smoker: ___Heavy (20+ cigs/day) __Moderate (10-19 cigs/day)___ Light (1-9 cigs/day)
How long since you last smoked?______________________________________

_______Non-Smoker

Drugs: Do you use illicit drugs? ____Yes ____No If yes, which one(s)? ______________________

____

Alcohol: How often did you have a drink containing alcohol in the past year?

____Never ____Monthly or less ____2-4x/month ____2-3x/week ___4+times/week

How many drinks did you have on a typical day when you were drinking?
____1-2 drinks ____3-4 drinks ____5-6 drinks ____7-9 drinks ____10+ drinks

How often did you have 6 or more drinks on one occasion in the past year?
____Never ____Less than once a month ____Monthly ____Weekly
____Daily or almost daily

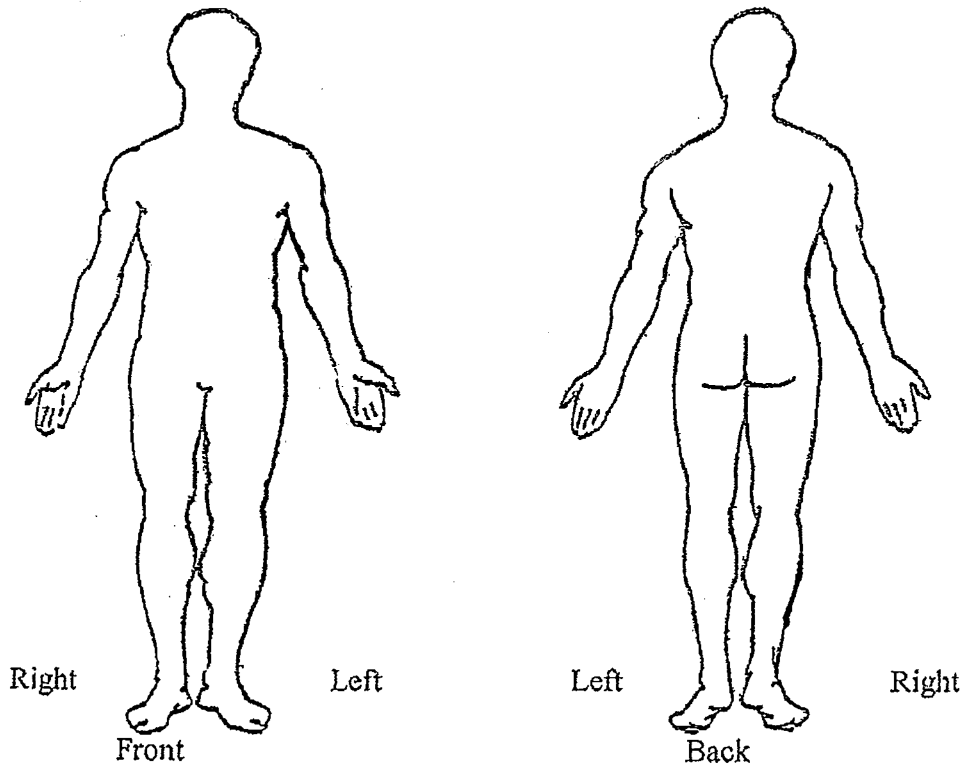
PATIENT/GUARDIAN SIGNATURE:____**DATE:**______________

PROVIDER SIGNATURE:____**DATE:**______________

NAME______________________________________ DATE __________

Where is your pain now?
Mark the areas where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture please draw in your face.

Aching	Numbness	Pins and Needles	Burning	Stabbing
>>>>>	= = = = =	000000000	xxxx	////



How bad is your pain now?

Please mark an X on the body form where the pain is more severe now.

On a scale from 1-10 please mark on the line how bad your pain is now.

No Pain 0   Worst Possible Pain 10

0____10