

# Alta Orthopaedics Patient Registration

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (Middle)

Social Security #: \_\_\_\_\_ Sex: Male Female

Home Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Primary Dr.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Dr. \_\_\_\_\_ Phone #: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Spouse/Parent: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Last) (First) (Middle)

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Card holders date of birth: \_\_\_/\_\_\_/\_\_\_ Social Security#: \_\_\_\_\_

**Payment Policy:** Payment is due at the time services are rendered, unless other arrangements have been made. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance. **Alta Orthopaedics does not accept HMO patients.** Please check with your insurance carrier directly to see if we are currently accepting their insurance plan.

**Patient Authorization:** I hereby authorize the release of any medical information necessary to process my insurance claim. Payors require SSN's to process their claims. I agree to be billed as self pay if I don't furnish this information. I hereby authorize payment of medical benefits to the named provider for services rendered. I also authorize National Heritage Ins. Co. to release information regarding Medicare claims submitted by the named provider.

**HIPPA Notice of Privacy Practices:** We are required by law to maintain the privacy of, and provide individuals with the HIPPA Regulations of our legal duties and privacy practices with respect to health information. If you have any objections to this form, please speak with our HIPPA Compliance Officer. The patient signature acknowledges receipt of this notice.

**Appointment cancellation policy:** Please give us 24 hours notice if you are not able to make your appointment. Our practice charges a \$45 fee for all missed appointments.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Alta Orthopaedics General Health Evaluation

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

What is being evaluated today? \_\_\_\_\_ Date symptoms began: \_\_\_\_\_

Have you seen another Dr. for this problem? Dr. \_\_\_\_\_

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Maximum weight: \_\_\_\_\_ Dominant hand: Left / Right

Please list your current medications: \_\_\_\_\_

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**Do you have any allergies to medications?** \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Packs per day: \_\_\_\_\_ for \_\_\_\_\_ years.

Do you drink alcohol? None Daily Socially Occasionally Rarely

Do you have any of these conditions? (Please circle below)

Cancer, Heart Trouble, High Blood Pressure, Rheumatic Fever, Diabetes, Arthritis, Gout,  
Difficulty Breathing (asthma/emphysema), Lung Disease, Fainting Spells, Jaundice/Hepatitis,  
Anemia/Bleeding Problems, Stomach Ulcers/Intestinal Problems, Circulation Problems, Aids or HIV, Infectious mono

Details: \_\_\_\_\_

Has any member of your family had any of these conditions? (Please circle below)

Cancer, Heart Trouble, High Blood Pressure, Rheumatic Fever, Diabetes, Arthritis, Gout,  
Difficulty Breathing (asthma/emphysema), Lung Disease, Fainting Spells, Jaundice/Hepatitis,  
Anemia/Bleeding Problems, Stomach Ulcers/Intestinal Problems, Circulation Problems

Details: \_\_\_\_\_

Have you ever been hospitalized or had surgery?

Date: \_\_\_\_\_ Procedure/illness: \_\_\_\_\_

Date: \_\_\_\_\_ Procedure/illness: \_\_\_\_\_

Have you had any of these tests? X-Ray, MRI, CT, Bone Scan, Nerve Conduction Test or Epidural Injection for this particular injury/Body part.

Date: \_\_\_\_\_ What? \_\_\_\_\_ Where? \_\_\_\_\_

Date: \_\_\_\_\_ What? \_\_\_\_\_ Where? \_\_\_\_\_