

Today's Date:



Patient Registration Form
Des Moines Orthopaedic Surgeons, P.C.

Medical Records #:

INFORMATION TO BECOME PART OF YOUR CONFIDENTIAL MEDICAL RECORD
(Please Print Your Information)

Complete the following information carefully.

PATIENT

Name (First, Middle, Last)		Home Phone (000) 000-0000		Work Phone (000) 000-000	
Street Address			City, State, Zip Code		
Age	Date of Birth (mm/dd/yy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Social Security # 000-00-0000	
<input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled					
Employer			Occupation (Title)		

Responsible Party Information (if other than patient)

Name (First, Middle, Last)		Home Phone (000) 000-0000		Work Phone (000) 000-000	
Street Address			City, State, Zip Code		
Date of Birth	Relationship to Patient	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Social Security # 000-00-0000	
<input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled					
Employer			Occupation (Title)		

Insurance Information

INSURANCE

Primary Insurance (BCBS, Medicare, etc.)		Cardholder's Full Name		Relationship to Patient	
Group Name or Employer (i.e.'ABC Company')		Identification Number		Group Number	
Secondary Insurance (BCBS, Medicare, etc.)		Cardholder's Full Name		Relationship to Patient	
Group Name or Employer (i.e.'ABC Company')		Identification Number		Group Number	

YOUR INSURANCE CARD WILL BE REQUIRED AT CHECK-IN.

Emergency Contact Information

NOTIFY

Full Name of Emergency Contact (not living with you)		Relationship to Patient		Home Phone (000) 000-0000	
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Nature of Illness or Injury

Brief Description of Orthopaedic Illness or Injury. Please Indicate Location (Left / Right / Both)

INJURY

Check Those That Apply: <input type="checkbox"/> Work Injury <input type="checkbox"/> Liability Accident <input type="checkbox"/> Motor Vehicle Accident	Date of Injury (mm/dd/yy)	If this is a work injury, has medical treatment been authorized by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Name and Address of Company and/or Representative (i.e. claims adjuster) to Contact for Verification		Phone Number (000) 000-0000
			Claim Number

Family Physician	Referring Physician
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OVER PLEASE

OVER PLEASE

READ CAREFULLY AND SIGN NAME BELOW

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize release of medical information necessary to process this (these) insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims:

- (1) a photocopy of other facsimile reproduction of this authorization, or
- (2) use of a computer to indicate my signature is on file at clinic, and/or
- (3) use of a computer to electronically transmit my claim for processing.

AUTHORIZATION TO ASSIGN MEDICAL BENEFITS TO CLINIC:

I certify that information provided relative to injury, illness, and insurance coverage is both true and correct. I authorize payment of insurance benefits or proceeds from any liability claim and legal/court settlement to be assigned to the physicians of this Clinic to the extent that their charges are paid in full.

ACKNOWLEDGEMENT OF INSURANCE LIMITATIONS:

Many insurance carriers require a written referral from a primary care physician (PCP) in advance of service (office visits, surgery, and diagnostic tests-- MRI). Patients, parents, or the guardians are responsible for (1) obtaining physician referrals and (2) contacting their insurance carrier to verify benefits in advance of service. Patients are also responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by their insurance company on our physician for seeing patients out-of-network. Co-payments are due at time of service.

ACKNOWLEDGEMENT OF PAYMENT RESPONSIBILITY:

Payment for medical services is between the Clinic (physician) and the patient. Payment is due in full according to the terms of this Clinic's credit policy. Therefore, I understand that this Clinic cannot accept responsibility for collecting or negotiating settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness liability claim, (4) claim where patient is/will be represented by an attorney, and/or (5) claim to be settled in a court of law.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I understand I have a right to review Des Moines Orthopaedic Surgeons, PC's (DMOS) Notice of Privacy Practices prior to signing this document. DMOS 's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of DMOS. The Notice of Privacy Practices for DMOS is also provided in the clinic registration area and on DMOS's website at www.dmos.com. This Notice of Privacy Practices also describes my rights and DMOS's duties with respect to my protected health information.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand DMOS will use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DMOS.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. DMOS is not required to agree to the restrictions that I may request. However, if DMOS agrees to a restriction that I request, the restriction is binding on DMOS and its providers.

DMOS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing DMOS 's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative _____

Description of Personal Representative's Authority / Relationship to Patient _____

THIS CLINIC ACCEPTS VISA, DISCOVER, MASTERCARD, PERSONAL CHECKS AND CASH.

CO-PAYMENTS ARE DUE AT TIME OF SERVICE.

Other Information:



DES MOINES ORTHOPAEDIC SURGEONS, P.C.

6001 Westown Parkway
West Des Moines, Iowa 50266

1301 Penn Avenue, Suite 213
Des Moines, Iowa 50316

311 South Clark Street, Suite 285
Carroll, Iowa 51401

DATE: _____

GENERAL HEALTH HISTORY

NAME: _____ SEX: M F AGE: _____

PERSONAL PHYSICIAN: _____ LAST CHECK UP: _____

HEIGHT: _____ WEIGHT: _____

ILLNESS:

Have you ever had:	Yes	No	Required Treatment	Required Hospitalization	Comments
Sleep Apnea	_____	_____	_____	_____	
High Blood Pressure	_____	_____	_____	_____	
Heart Disease	_____	_____	_____	_____	
Diabetes	_____	_____	_____	_____	
Asthma	_____	_____	_____	_____	
Pneumonia	_____	_____	_____	_____	
Blood Clots	_____	_____	_____	_____	
Ulcer	_____	_____	_____	_____	
Kidney Disease	_____	_____	_____	_____	
Anemia	_____	_____	_____	_____	
Seizures	_____	_____	_____	_____	
Liver Disease/Hepatitis	_____	_____	_____	_____	
Fibromyalgia	_____	_____	_____	_____	

PAST SURGERIES:

Yes	No		When: _____	Comments
_____	_____	Appendectomy	When: _____	
_____	_____	Gallbladder	When: _____	
_____	_____	Hernia Repair	When: _____	
_____	_____	Hysterectomy	When: _____	
_____	_____	Coronary (Heart) Catheterization	When: _____	
_____	_____	Coronary Artery Bypass	When: _____	
_____	_____	Pacemaker	When: _____	
_____	_____	Lower Extremity Bypass	When: _____	
_____	_____	Prostate	When: _____	
_____	_____	Joint Surgery	When: _____	Type _____
_____	_____	Back Surgery	When: _____	
_____	_____	Wound Infections	When: _____	
_____	_____	Anesthesia Complications	When: _____	
_____	_____	Other _____	When: _____	

CURRENT MEDICATIONS: (Include Herbal Supplements/Over-the-Counter Medications)

	Dose	Times/Day
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

ALLERGIES TO MEDICATIONS:

	Yes	No		Yes	No	
1. _____	_____	_____	Penicillin	6. _____	_____	Novocain/Local Anesthetics
2. _____	_____	_____	Sulfa	7. _____	_____	Iodine
3. _____	_____	_____	Demerol	8. _____	_____	Latex
4. _____	_____	_____	Morphine	9. _____	_____	Other: _____
5. _____	_____	_____	Codeine			

Please describe any reaction to drug(s): _____

SOCIAL HISTORY:

Marital Status: Single Married Divorced Separated Widow(er)

Occupation: _____

Living: I live in a Home _____ Apt. _____ Retirement Complex _____ Other _____
I live With Spouse _____ Alone _____ Other _____

Habits:

Yes No
____ ____ Smoke Packs per day _____ How many years _____
____ ____ Alcohol Average consumption per week _____
____ ____ Coffee Cups per day _____

Alive Deceased Age Health Status or Cause Of Death

FAMILY HISTORY:

	<u>Alive</u>	<u>Deceased</u>	<u>Age</u>	<u>Health Status or Cause Of Death</u>
Grandmother (mom's)	A	D	_____	_____
Grandfather (mom's)	A	D	_____	_____
Grandmother (dad's)	A	D	_____	_____
Grandfather (dad's)	A	D	_____	_____
Father	A	D	_____	_____
Mother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____

REVIEW OF SYSTEMS:

	Yes	No	(If Yes, Please Circle – Current Symptoms Only)
1.	____	____	Fevers, chills, sweats
2.	____	____	Loss of appetite, loss of weight
3.	____	____	Chest pain, shortness of breath, rapid or irregular heart beat, swollen ankles, fainting spells
4.	____	____	Persistent cough, cough up blood, difficulty breathing, emphysema, pneumonia, TB
5.	____	____	Heart burn, ulcer, vomited blood, jaundice, hepatitis
6.	____	____	Bladder infection, kidney stones, blood in urine
7.	____	____	Headache, dizzy spells, seizures, stroke, head injury
8.	____	____	Rheumatoid arthritis, gout, lupus
9.	____	____	Depression, nervous breakdown
10.	____	____	Thyroid trouble, elevated blood sugar
11.	____	____	Anemia, blood clots, bleeding problems, phlebitis
12.	____	____	Cancer: (Type) _____

Your orthopaedic problem (Briefly describe current problem and location, duration of symptoms, history of trauma and previous treatments tried.):

[Do Not Write Below Line – For Office Use Only]

REVIEWED AND UPDATED

PHYSICIAN

DATE

