CORE ORTHOPEDICS & SPORTS MEDICINE
REGISTRATION INFORMATION

I. PATIENT INFORMATION: Social Security No.: _____

Legal Name: _____ Age: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Driver's License No.: _____ Employer's or School Name: _____

Employer or School Address: _____ City: _____ State: _____ Zip: _____

In case of Emergency, who should be notified? _____

Phone: _____ Relationship: _____

Who is your Medical Doctor or Primary Care Physician? _____

II. GURANTOR INFORMATION: (If different from Patient) Social Security No.: _____

Legal Name: _____ Age: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Driver's License No.: _____ Employer's or School Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

III. PRIMARY INSURANCE INFORMATION

Name of Ins. Co.: _____ Policy ID No.: _____

Group No.: _____ Phone No.: _____ Co-Payment: $ _____ Referral Needed: ☐ Yes ☐ No

If different than patient, fill in below:

Name of Policy Holder: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Employer: _____

IV. SECONDARY INSURANCE INFORMATION

Name of Ins. Co.: _____ Policy ID No.: _____

Group No.: _____ Phone No.: _____ Co-Payment: $ _____ Referral Needed: ☐ Yes ☐ No

If different than patient, fill in below:

Name of Policy Holder: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Employer: _____

V. WORKER'S COMPENSATION OR LEGAL/ACCIDENT (If applicable)

Name Carrier: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No.: _____ Claim No.: _____ Name of Adjuster: _____

Employer at Time of Accident: _____ Phone No.: _____

Name of Attorney: _____ Phone No.: _____

Verification of W/C: ☐ Yes ☐ No Date Made: _____ by: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage and assign directly to Core Orthopedics & Sports Medicine and its affiliates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the use of my health care information and such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services. The consent will end upon termination of coverage with the above-named Insurance Company(ies) or one year from the date signed below.

X _____ **X** _____

Signature of Patient, Parent, Guardian or Personal Representative — Signature of Patient, Parent, Guardian or Personal Representative

Date: _____ Date: _____

☐ Parent ☐ Spouse ☐ Guardian/POA

Yearly Annual Review (Only Sign if Updating Form)

I have reviewed the above registration information and find it to be correct & updated.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

CORE ORTHOPEDICS & SPORTS MEDICINE

PATIENT ASSESSMENT

PLEASE PRINT USING BLACK OR BLUE PEN ONLY.

Patient's Legal Name: (Last) (First) (M.I.)

Patient's Age:_____Years Date of Birth: / / Height: (Ft) (In) Weight:

This form is being completed by: ☐ Patient ☐ Spouse ☐ Parent ☐ Guardian ☐ Other:

Who is your Medical Doctor or Primary Care Physician?

Name:_____

Address:_____

City:_____ State Zip

Phone:( )_____

Who referred you to Core?

☐ Friend ☐ E.R./Hosp. ☐ Yellow Pages

☐ Doctor_____ ☐ Other

Occupation:_____

How long have you been doing this work?_____

Pharmacy Name:_____ Pharmacy Phone: ( )_____

HISTORY OF PRESENT ILLNESS (HPI)

Where is your pain located? _____ ☐ RIGHT ☐ LEFT
(Example: wrist, ankle, low back)

Which is your dominant hand? ☐ RIGHT ☐ LEFT

Approximate **date** of the onset of the present problem: _____

How did **this** problem occur? _____

Any previous problems to **this** area? ☐ No ☐ Yes If yes, describe: _____

1. Who have you seen for **this** problem? ☐ Not Previously Seen ☐ Family Physician
   ☐ Emergency Room _____ ☐ Other _____
   (Hospital)
2. Check off all past tests or treatments for **this** problem: ☐ X-ray ☐ Splint ☐ Medication ☐ Physical Therapy
   ☐ MRI ☐ Surgery ☐ Other _____
3. Intensity of pain (circle one): **None** 1 2 3 4 5 6 7 8 9 10 **Severe**
4. My pain is: ☐ Intermittent ☐ Constant
5. When do symptoms occur? _____
   (Example: after exercise, after long walks, after sitting for long periods of time, etc.)
6. Type of pain: ☐ Burning ☐ Aching ☐ Stabbing ☐ Sharp
   ☐ Shooting ☐ Deep ☐ Other _____
7. Does the pain radiate? ☐ No ☐ Yes To where? _____

   If you have neck pain, what percentage is neck pain ____%, and what percentage is radiating pain to arm ____%
   (Example: 80% neck pain, 20% arm pain)

   If you have back pain, what percentage is back pain ____%, and what percentage is radiating pain to leg ____%
   (Example: 50% back pain, 50% leg pain)

MEDICAL HISTORY

	NO	YES		NO	YES		NO	YES
Anemia	☐	☐	Heart attack	☐	☐	Shingles	☐	☐
Alzheimers	☐	☐	Heart palpitations	☐	☐	Steroid Use	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	Stomach ulcers	☐	☐
Bladder control problems	☐	☐	Kidney disease	☐	☐	Stroke/TIA	☐	☐
Bladder infections	☐	☐	Liver disease	☐	☐	Thyroid disease	☐	☐
Bleeding tendency	☐	☐	Lupus erythematosus	☐	☐	Tuberculosis	☐	☐
Blood clots (DVT) *site* _____	☐	☐	Migraine headache	☐	☐	Varicose veins	☐	☐
Cancer *site* _____	☐	☐	Osteoarthritis	☐	☐			
Diabetes	☐	☐	Osteoporosis	☐	☐	Anxiety	☐	☐
Diverticulitis	☐	☐	Pneumonia	☐	☐	Depression	☐	☐
Emphysema/COPD	☐	☐	Psoriasis	☐	☐	Hepatitis A, B, or C	☐	☐
Esophageal reflux (GERD)	☐	☐	Rheumatoid arthritis	☐	☐	HIV	☐	☐
Glaucoma	☐	☐	Sciatica	☐	☐	Seizures	☐	☐
Gout	☐	☐						

Any other medical problems not listed?_____

PAST SURGICAL / HOSPITALIZATION HISTORY

Year	Hospital/Location	Reason

MEDICATION HISTORY

Please include prescription drugs, vitamins and drugs you buy over the counter.

	Medication	Dose/Strength	When do you take it?	Reason you take the medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ALLERGIES - List any allergies you have and what type of allergic reaction you experience.

☐ NO ALLERGIES

1. Allergy:	Reaction:
2. Allergy:	Reaction:
3. Allergy:	Reaction:
4. Latex Allergy: ☐ Yes ☐ No	Reaction:

SOCIAL HISTORY

Do you smoke? ☐ NO ☐ YES Packs/Day_____ Years_____

Do you drink alcohol? ☐ NO ☐ YES Drinks/Day_____ Years_____

Do you take a special diet? ☐ NO ☐ YES Describe:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated **Do you live alone?** ☐ NO ☐ YES

Home Environment: ☐ Apartment ☐ Private house
☐ Elevator ☐ Outside Steps ☐ Inside Stairs

Were you independent in your activities of daily living prior to your injury? ☐ NO ☐ YES If no, please describe:

_____

FAMILY HISTORY: (Please list any medical problems in your relatives.)

Father:_____ Mother:_____ Siblings:_____

Others:_____ _____

OBSTETRICAL HISTORY (FOR FEMALES ONLY):

Are you currently pregnant? ☐ YES ☐ NO No. of Children:____ No. of Pregnancies:____ No. of Deliveries:____

REVIEW OF SYSTEMS (ROS)

Please indicate which, if any, of the following problems you have by circling YES or NO:

Constitutional
Good general health ☐ Yes ☐ No
Recent weight change ☐ Yes ☐ No
Night sweats, fevers ☐ Yes ☐ No
Fatigue ☐ Yes ☐ No

Cardiovascular
Chest pain ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Heart trouble ☐ Yes ☐ No
Swelling hands/feet ☐ Yes ☐ No

Musculoskeletal
Muscle pain or cramps ☐ Yes ☐ No
Stiffness/swelling joints ☐ Yes ☐ No
Joint pain ☐ Yes ☐ No
Trouble walking ☐ Yes ☐ No

Endocrine
Excessive thirst/urination ☐ Yes ☐ No
Hormone problem ☐ Yes ☐ No

Genitourinary - Male Only
Blood in urine ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Sexual problems ☐ Yes ☐ No
Testicle pain ☐ Yes ☐ No

Ears / Nose / Mouth / Throat
Hearing loss or ringing ☐ Yes ☐ No
Sinus problems ☐ Yes ☐ No
Nose bleeds ☐ Yes ☐ No
Sore throat/voice change ☐ Yes ☐ No

Respiratory
Shortness of breath ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Coughing up blood ☐ Yes ☐ No

Neurological
Frequent headaches ☐ Yes ☐ No
Paralysis or tremors ☐ Yes ☐ No
Numbness/tingling ☐ Yes ☐ No

Hematologic / Lymphatic
Bruise easily ☐ Yes ☐ No
Slow to heal ☐ Yes ☐ No
Enlarged glands ☐ Yes ☐ No

Genitourinary - Female Only
Blood in urine ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Sexual problems ☐ Yes ☐ No
Menstrual problems ☐ Yes ☐ No

Eyes
Wear glasses/contacts ☐ Yes ☐ No
Blurred/double vision ☐ Yes ☐ No
Eye disease or injury ☐ Yes ☐ No

Gastrointestinal
Nausea/vomiting ☐ Yes ☐ No
Abdominal pain ☐ Yes ☐ No
Rectal bleeding ☐ Yes ☐ No
Bowel problems ☐ Yes ☐ No

Integumentary (Skin / Breast)
Change in hair or nails ☐ Yes ☐ No
Rashes or itching ☐ Yes ☐ No
Breast lump ☐ Yes ☐ No
Breast pain or discharge ☐ Yes ☐ No

Allergic / Immunologic
Food allergies ☐ Yes ☐ No
Aspirin allergies ☐ Yes ☐ No
Antibiotic allergies ☐ Yes ☐ No

Psychiatric
Insomnia ☐ Yes ☐ No
Confusion/memory loss ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Substance Abuse ☐ Yes ☐ No

CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY :
I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge.

Patient's or Responsible Party's Signature:_____ Date:_____

Patient's or Responsible Party's Signature:_____ Date:_____

CERTIFICATION BY PHYSICIAN:
I have reviewed the information contained in this Patient Assessment with the patient named within or Responsible Party who submitted the information in the Patient's behalf.

Physician's Signature:_____ Date:_____ Physician's Signature:_____ Date:_____

Physician's Signature:_____ Date:_____ Physician's Signature:_____ Date:_____

Temp_____ Pulse_____ ☐ Reg ☐ Irreg. Resp._____

UNIVERSAL CONSENT FORM

PATIENT NAME: _____

CONSENT FOR TREATMENT

It is my wish to be treated by Core Orthopedics & Sports Medicine. I give permission for Core physicians, physician assistants, chiropractic physicians and clinical employees caring for me to treat me in ways they judge will be beneficial. I further consent to any medication, examinations, X-rays, tests or minor procedures that my Core physician determines to be necessary. I understand my Core physician will explain to me the nature of my condition, his/her recommended treatment and any associated risks involved. I also understand that he/she will explain to me other ways this condition could be treated. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in this facility.

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

I have been given an explanation and a copy of Core "HIPAA Notice of Privacy Practices" and understand that I may call Core Privacy Official if I have any questions regarding the content of this notice. I further understand that my medical record is considered privileged information and, as such, is protected by State and Federal laws. Core may use my information for purposes of treatment, payment and its operations as described in the notice of privacy practices.

I understand that except as regulated by law, my medical record information will not be released should I refuse to sign this form. Therefore, I may be financially responsible for all costs incurred by me for treatment if a revocation or refusal to disclose information results in payment denial of my insurance claim.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize payment to Core Orthopedics & Sports Medicine and its physicians (who agree to accept this assignment) and assign all of my rights and claims for reimbursement of expenses allowable under Medicare, Medicaid, Workers Compensation, or any other health plans under which I may be entitled to reimbursement. I understand that I am financially responsible to Core for charges not covered by my insurance and this assignment.

In consideration of medical services provided by Core to the above-identified patient, I agree to pay to Core all applicable fees and charges. In the event that this obligation remains unpaid and requires referral for collection, I agree to pay all costs of collection and/ or reasonable attorney fees. I hereby authorize my attorney to pay Core any outstanding balances due immediately upon receipt of any Workers' Compensation and/or Third Party Insurance Case settlement.

DISCLOSURE OF OWNERSHIP

Core is required to inform you that several of our physicians are investors in Core Orthopedics & Sports Medicine.

ACKNOWLEDGE OF RECEIPT OF PAYMENT

I acknowledge that I have read and understand the Core Orthopedics & Sports Medicine Payment Policy.

Medicare Certification and Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I have provided, as appropriate, the information related to Medicare as a secondary payor as it applies to my Medicare health care insurance. X _____ Initials of Guarantor / Patient
Sharing Of Medical Information: I hereby authorize Core to share my registration, medical history, billing, insurance information, etc. within its own network. The sharing of information should avoid having you complete an identical form a second time and allow our staff to pre-approve tests or procedures more quickly, thereby expediting your medical care when utilizing other services within Core. X _____ Initials of Guarantor / Patient

I have read and understand the above information and agree to its content:

_____ _____
Signature (Patient/Parent/Legal Guardian) Date

_____ _____
Signature of Guarantor (if other than above) Date

_____ _____
Signature (Patient/Parent/Legal Guardian) Date

CORE
ORTHOPEDICS & SPORTS MEDICINE
Daniel T. Kuesis, M.D.
Gregory Drake, D.O.

Confidential Communications of Protected Health Information

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable. Please indicate your request regarding communication below, and answer ALL the questions listed. If it does not apply, please mark the NA field.

Today's Date: _____ Account #_____

Patient Name:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

CONFIDENTIAL INFORMATION (including results, medical information)

Contact me at my home.	Yes ☐	No ☐	NA ☐
Leave message on my home answering machine.	Yes ☐	No ☐	NA ☐
Leave message with persons at my home.	Yes ☐	No ☐	NA ☐
Call me on my cell phone.	Yes ☐	No ☐	NA ☐
Leave message on my cell phone voice mail.	Yes ☐	No ☐	NA ☐
Contact me at my work.	Yes ☐	No ☐	NA ☐
If yes, OK to leave a message?	Yes ☐	No ☐	NA ☐
Do you have a Medical Power of Attorney Assigned?	Yes ☐	No ☐	NA ☐

Do you want a family member to have access to your personal health information (spouse, parent, child)? If so, please list their name and relationship to you.

Name: _____ Relationship: _____

Phone #: _____ Cell/Home/Work: _____

Can we send sealed confidential information to your home address? Yes ☐ No ☐

If no, list another address: _____

Other requests for confidential communications:_____

Patient Signature:_____

Core Orthopedics & Sports Medicine