

MONTANA ORTHOPEDICS Registration Form

(Please Print)



PATIENT INFORMATION

Date:		Patient's last name:			First:		Middle:						
<input type="checkbox"/> Miss	<input type="checkbox"/> Mr.	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid.			Social Security no.:		Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Ms.	<input type="checkbox"/> Mrs.												
Mailing Address:				City:		State:	Zip:	Home phone no.:		Cell phone no.:			
Occupation:		Employer:						Employer phone no.:					
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled													
Chose clinic because / Referred to clinic by (please check one box):							<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital		
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other					
Have you been seen for this condition by another provider?					<input type="checkbox"/> No <input type="checkbox"/> Yes		Dr.						
Have you had X-rays taken for this condition?					<input type="checkbox"/> No <input type="checkbox"/> Yes		When:						

PAYMENT INFORMATION

If patient is a minor (under 18 yrs of age) please list parent name											
Person responsible for payment:			Address (if different):				Home phone no.:		Cell phone no.:		
Social Security No.:		Employer:		Employer address:				Employer phone no.:			
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No											

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company:			Subscriber's name:			Subscriber's S.S. no.:		Subscriber's D.O.B.:			
Company's Address (Street or Box, City, ST. Zip Code):						Group no. or name:		Policy no.:			
Name of secondary insurance (if applicable):			Subscriber's name:			Subscriber's S.S. no.:		Subscriber's D.O.B.:			
Company's Address (Street or Box, City, ST. Zip Code):						Group no.:		Policy no.:			

WORKERS' COMPENSATION/AUTO ACCIDENT INFORMATION

Claim No.:		Date of Accident:		Location of Accident:			Employer's Name & Phone No.:		
Have you filed a written claim with your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No									

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):				Relationship to patient:		Home phone no.:		Work phone no.:	
						()		()	

AUTHORIZATION: By making this appointment, I hereby allow treatment for the above named minor or myself by the Physicians, or staff of Montana Orthopedics. I have also been apprised of my rights under the Health Information Portability and Accountability Act of 1996 (HIPAA) and authorize the release of medical information to my insurance company in order to obtain payment for services rendered and insurance benefits to be paid directly to Montana Orthopedics. **I have read and agree with the Montana Orthopedics and Advantage Physical Therapy Financial Policy.**

Patient/Guardian signature

Date

MT-2

ORTHOPEDIC HISTORY

Name:		Date:	
--------------	--	--------------	--

CHIEF COMPLAINT

WHAT ARE YOU BEING SEEN FOR TODAY?

1.	
2.	

PROBLEMS ADDRESSED	DATE OF INJURY	ONSET OF PROBLEM
<input type="checkbox"/> Work Injury		
<input type="checkbox"/> Car Accident		
<input type="checkbox"/> Home/School/Sports Injury		
<input type="checkbox"/> No injury/Chronic problem		

REVIEW OF SYSTEMS

RISK FACTORS REVIEWED

Are you currently having or have you had problems with your:	YES	NO
Constitutional Symptoms (fever, weight loss, fatigue)		
Eyes (double vision, blurring, trauma, glasses)		
Cardiovascular (chest pain, palpation, high blood pressure, irregular heartbeats)		
Respiratory (shortness of breath, asthma, cough, cough producing bloody mucous)		
Stomach (appetite, weight changes, diarrhea, constipation, abdominal pain)		
Bowel/Bladder (hesitancy, incontinence, painful urination, pregnancies)		
Musculoskeletal (fractures, sprains, pain, swelling, arthritis, stiffness, muscle wasting)		
Skin/Breast (color, temperature, rashes, lesions, scars, masses, ulcers)		
Neurological (difficulty w/speech or swallowing, history of stroke, numbness, tingling, seizures, weakness, visual changes, Balance, memory, coordination problems)		
Psychological (depression, mood changes, hallucination, sleep disturbances)		
Endocrine (excessive thirst, excessive eating, hyperactivity, growth or hair changes)		
Hematological/Lymphatic (bleeding tendency, enlarged or painful lymph nodes, anemia, allergies, HIV)		

Are you currently being treated for any of these conditions?

Primary Care Physician:

PERSONAL HEALTH HISTORY

SURGERIES

Year	Reason	Complications

OTHER HOSPITALIZATIONS

Year	Reason	Complications

Have you had any problems with anesthesia? NO YES Describe:

List your prescribed drugs and over-the counter drugs, such as vitamins and inhalers

Name the Drug	Dose	Reason for Medication

Allergies to medications

Name the Drug	Reaction You Had

FAMILY HISTORY

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Other illness
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Deformity	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Cancer	<input type="checkbox"/> Other abnormalities	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/>

SOCIAL HISTORY

OCCUPATION:

Employment Status	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Student
	<input type="checkbox"/> Disabled	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Work in the home		
Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Never married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
	Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of children: _____		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation less than 4X/week for 30 minutes)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind? <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Other			
	<input type="checkbox"/> Daily	<input type="checkbox"/> 1-2 X/week	<input type="checkbox"/> 1-2 X/month	<input type="checkbox"/> 1-2 X/year
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes ____ pks./day	<input type="checkbox"/> Chew ____ cans/day	<input type="checkbox"/> Pipe ____ #/day	<input type="checkbox"/> Cigars ____ #/day
	<input type="checkbox"/> ____ # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreation or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?			<input type="checkbox"/> Yes <input type="checkbox"/> No