Tidewater Orthopaedics
Specialized Care You Can Trust

TIDEWATER ORTHOPAEDICS PATIENT REGISTRATION FORM

Patient Information				
Patient's last name:		**Patients first name:**		**Middle initial:**
Is this your legal name? Yes ◯ No ◯	**If not, what is your legal name?**		**Former name:**	
Date of birth (mm/dd/yyyy):	**Age:**	**Sex:**	**Marital status:**	**Social security no.:**
Responsible party (*if minor*):				
Address:				
Home phone:	**Cell phone:**		**Work phone:**	
E-mail:				
Employer:			**Occupation:**	
Primary Care Physician (PCP):				
Pharmacy name:			**Pharmacy location/phone no.:**	
Race: ☐ White ☐ African-American/Black ☐ American Indian/Alaska Native ☐ Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Asian ☐ Other			**Language:** ☐ English ☐ Spanish ☐ Other:_____	
********How did you hear about us?********				

********In Case of Emergency********			
Name of emergency contact:	**Relationship to patient:**	**Home phone:**	**Work phone:**

Authorized Person(s) to Release Medical Information
Include all individuals allowed to access your medical information even if listed as your emergency contact
Person(s) allowed to have full access to the patient's medical record (including forms, prescriptions/Rx, and financials)

Authorized person #1:	**Birth date:**	**Phone number:**	**Relationship to patient:**
Authorized person #2:	**Birth date:**	**Phone number:**	**Relationship to patient:**

Insurance Information				
Are you represented by an attorney for this injury? Yes ◯ No ◯		**If yes, attorney's name:**		**Attorney phone no.:**
Person responsible for bill:	**Birth date:**	**Address (if different):**		**Phone number:**
Primary insurance:	**Subscribers name:**		**Subscribers DOB:**	**Subscribers social security no.:**
Policy no.:	**Group no.:**		**Patients relationship to subscriber:**	
Secondary insurance (*if applicable*):	**Subscribers name:**		**Subscribers DOB:**	**Subscribers social security no.:**
Policy no.:	**Group no.:**		**Patients relationship to subscriber:**	

The above information is true to the best of my knowledge. I authorize insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Tidewater Orthopaedic Associates or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature **Date**

Tidewater Orthopaedics complies with all Federal Civil Rights Laws and does not discriminate based on race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.

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TIDEWATER ORTHOPAEDICS HEALTH HISTORY FORM

Patient name: _____ **Date of birth (mm/dd/yyyy):**_____ **Height:**_____ **Weight:** _____

Main reason for today's visit: _____

Please circle your current level of pain: (0 = no pain, 10 = worst pain you've had) 0 1 2 3 4 5 6 7 8 9 10

Medications

Please list (or we can make a copy of your medication list) all prescriptions and non-prescription medications, vitamins, home remedies, herbs, and inhalers. If you need more room please continue on the back of this form _____

_____

_____

☐ **I TAKE NO MEDICATIONS**

Personal Medical History

Do you currently or have you had in the past any of the following conditions?

☐ AIDS/HIV	☐ Angina	☐ Atrial Fibrillation	☐ Bladder Infection
☐ Bleeding Disorder	☐ Bronchitis	☐ Cancer	☐ DVT/PE
☐ Chemical Abuse	☐ Depression	☐ Diabetes	☐ Elevated Cholesterol
☐ Emphysema	☐ Gall Bladder Disease	☐ Seizures	☐ Heart Disease
☐ Hepatitis	☐ High Blood Pressure	☐ Intestinal Disorder	☐ Kidney Disease
☐ Mental Disorder	☐ Pneumonia	☐ Skin Disease	☐ Stroke
☐ Thyroid Disease	☐ Tuberculosis	☐ Ulcers	☐ Other (please specify):_____

Please check/list any allergies and/or intolerances to medications:

☐ Penicillin	☐ Sulfa	☐ Latex	☐ Shellfish
☐ Codeine	☐ Other (please specify): _____		

_____

☐ **NO KNOWN ALLERGIES**

Surgical History and Hospitalizations

Please list any surgeries, procedures, and/or reasons for hospitalization you have had in the past five years (please include the year of surgery and/or hospitalization):_____

_____

_____

☐ **NO SURGICAL HISTORY OR HOSPITALIZATIONS**

Family History

Please check the box that applies to the corresponding family member. If you were adopted and/or do not know your family history please skip this section

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer	Deceased (age)
Father							
Mother							
Brother(s)							
Sister(s)							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							

Social History

Do you smoke cigarettes? ☐ Yes | ☐ No ☐ Former Smoker

Do you drink alcohol? ☐ Yes | ☐ No

If yes, how many drinks per day? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

How often? ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

The government classifies you as an alcoholic if you have more than 4 drinks per day

Female patients – Do you take birth control? ☐ Yes | ☐ No

Is there a chance you are pregnant? ☐ Yes | ☐ No

Review of Systems

Please check all that apply:

General: ☐ None ☐ Chills ☐ Fever ☐ Weight change

HEENT: ☐ Double/Blurred vision ☐ Recent cold ☐ Hearing loss ☐ Ringing in ears ☐ Sore throat

Respiratory: ☐ None ☐ Shortness of breath ☐ Wheezing

Cardiovascular: ☐ None ☐ Rheumatic fever ☐ Heart murmur ☐ Chest pain ☐ Palpitations

Gastrointestinal: ☐ None ☐ Hemorrhoids ☐ Gas/Bloating ☐ Abdominal pain ☐ Blood in stool ☐ Diarrhea ☐ Difficulty swallowing ☐ Heartburn ☐ Nausea ☐ Vomiting

Genitourinary: ☐ None ☐ Blood in urine ☐ Frequent urination ☐ Burning sensation ☐ Incontinence ☐ Bladder/Kidney infection

Musculoskeletal: ☐ None ☐ Gout ☐ Rheumatoid disease ☐ Fracture/Dislocation ☐ Joint stiffness ☐ Joint pain ☐ Swollen joints

Skin: ☐ None ☐ Psoriasis ☐ Varicose veins ☐ Raynaud's ☐ Itching ☐ Rash

Neurologic: ☐ None ☐ Dizziness ☐ Headache

Psychiatric: ☐ None ☐ Bipolar disorder ☐ Seizure disorder ☐ Depression