# REGISTRATION INFORMATION

| Office Use Only |
|---|
| Doctor: ______ |
| Date: ______ |

## PATIENT INFORMATION:

Patient Legal Name: ______

Date of Birth: ______ Social Security#: ______

Age: ______ Sex: ______ Marital Status: ______ Spouse's Name: ______

Street Address: ______ P.O. Box #: ______

City: ______ State: ______ Zip Code: ______

If you currently reside in a nursing facility please list name & address of the facility ______

Home Phone #: ______ Cell Phone #: ______

Employer: ______ Work Phone #: ______

Emergency Contact (Not Living with You): ______ Phone #: ______

## PARENT INFORMATION: (If the Patient is under 18, please include Parents information)

Parent Name: ______

Date of Birth: ______ Social Security#: ______

Employer: ______ Work Phone #: ______

## REASON FOR APPOINTMENT:

Problem: LEFT / RIGHT / BOTH ______ Accident Date: ______

If seen at a Hospital / ER, please list Hospital name and Date seen: ______

Family Physician: ______ Referring Physician: ______

## INSURANCE INFORMATION:

| Subscriber Information: Primary | Subscriber Information: Secondary |
|---|---|
| Insurance Name | Insurance Name |
| Subscribers Name | Subscribers Name |
| Subscribers Date of Birth and SS# | Subscribers Date of Birth and SS# |
| Subscribers Employer | Subscribers Employer |

AUTHORIZATION TO PAY PHYSICIAN AND RELEASE INFORMATION:

I hereby authorize payment directly to the **Ozark Orthopaedics.**

I also authorize the clinic to release any information acquired in the course of examination and/or treatment to my insurance company and/or attorney. I am in compliance with the HIPAA Laws, and have been offered a copy of the Privacy Practices, I authorize treatment.

I agree that Ozark Orthopaedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature: ______ Date: ______

# Medical History

Name : ______________________ Sex: __________ Age: __________

Date of Birth : ______________________ Family Doctor ______________________

Ht __________ Wt __________

Chief Complaint ______________________

Review of Systems: Please check any medical problems you have had or now have :

**Allergies to Medicines : YES NO**

**Please List :**

______________________

______________________

______________________

**Eyes :** Cataracts ______ Glaucoma ______ Vision Loss ______

**ENT :** Hearing Loss ______ Ear Infection ______

**Heart :** Heart Disease ______ Hypertension ______ Stroke ______ Mitral Prolapse ______ Atrial Fib ______

**Lungs :** Asthma ______ Emphysema ______ Pneumonia ______

**GI :** Ulcers ______ Gall Bladder ______ Diverticulitis ______ Crohn's Disease ______

**GU :** Kidney Disease ______ Bladder Problem ______ Prostate Disorder ______ Menstrual Problem ______

**Skin :** Eczema ______ Rashes ______ Lesions ______

**Neuro :** Seizures ______ Paralysis ______ Migraines ______ MS ______ Other ______

**Endo :** Diabetes ______ Hepatitis ______ Thyroid Disease ______

**Hemat :** Anemia ______ Bleeding Tendency ______

**Constit :** Weight Loss ______ Fevers ______

**Allergy :** Hay Fever ______ Dust ______ Latex ______

**Bone Density Test:** **No** **Yes**

**If yes, Date** ______________

List major illnesses : (Cancer, Arthritis) Mo/Yr

______________________

______________________

______________________

List prior surgeries :

______________________

______________________

Current medications : (Circle or List)

Cortisone Coumadin Insulin Methotrexate

______________________

______________________

______________________

Do you have any other medical problems we have not noticed:

______________________

______________________

Do you smoke ? __________ How Much ? __________

Do you drink ? __________ How Much ? __________

Family history : Mother : Alive____Deceased____Age____
Father : Alive____Deceased____Age____

List any major illnesses of any blood relatives :

______________________

______________________

______________________

**Physician Review :**

Date: ______________ Signature: ______________

## OZARK ORTHOPAEDICS

☐ 3317 N. Wimberly Drive
Fayetteville, AR 72703
(479) 444-6942 fax

☐ 1101 Horsebarn Rd
Rogers, AR 72758
479-271-2133

☐ 1675 W Jefferson Ste D
Siloam Springs, AR 72761
479-571-3842

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE**
**OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize Ozark Orthopaedics to use and/or disclose certain protected health information (PHI) about me to: (name)

____________________________________

____________________________________

____________________________________

*This authorization permits Ozark Orthopaedics to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, level of detail to be released, origin of information, etc.):*

__________________________________________________________

**Any additional notes/Information:** ____________________________________

__________________________________________________________

This authorization will expire on: One year from signature date unless otherwise noted.

I do not have to sign this authorization in order to receive treatment from Ozark Orthopaedics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy Officer at:

☐ **Ozark Orthopaedics**
**3317 N. Wimberly**
**Fayetteville, AR 72703**
**Fax 479-444-6942**

☐ **Ozark Orthopaedics**
**1101 Horsebarn Rd**
**Rogers, AR 72758**
**Fax 479-271-2139**

☐ **Ozark Orthopaedics**
**1675 W Jefferson Ste D**
**Siloam Springs, AR 72761**
**Fax 479-549-3733**

Signed by: __________________________ __________________________
Signature of Patient or Guardian | Relationship to Patient

__________________________ __________________________
Patient's Name | Date of Birth

__________________________ __________________________
Print Name of Patient or Legal Guardian | Date