

**PATIENT REGISTRATION**

Date: \_\_\_\_\_

Patient's Name: Last: \_\_\_\_\_

First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Male  Female  SSN: \_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Preferred phone number:** \_\_\_\_\_

**Ethnicity:**  Hispanic  Non-Hispanic  Prefer not to answer

**Race:**  American Indian  Asian  Black  Native Hawaiian  Unknown  White

Married  Single  Divorced  Separated  Widowed

**Referred by:** \_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Preferred Language:** \_\_\_\_\_

Employer: \_\_\_\_\_

Were you injured? Yes  No  Date of injury: \_\_\_\_\_

Employer address: \_\_\_\_\_

On the job? Yes  No

City/State/Zip: \_\_\_\_\_

An auto accident? Yes  No

Occupation: \_\_\_\_\_

Other: \_\_\_\_\_

Do you have an attorney? Yes  No

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

**Primary Insurance**

**Secondary Insurance**

Carrier Name: \_\_\_\_\_

Carrier Name: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

Subscriber's date of birth: \_\_\_\_\_

Subscriber's date of birth: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Responsible party: patient  other

Name of other responsible party: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Phone: \_\_\_\_\_

Location: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Phone: \_\_\_\_\_

PATIENT REGISTRATION

**Patient Name: Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Bowling Orthopaedics wants to be helpful in every way possible. We are happy to assist you with prior authorization and filing claims. Some insurance policies require prior authorization for your office visit. Please check your policy and ensure authorization is received, if required. Your insurance policy remains a contract between you and your carrier, not Bowling Orthopaedics and your carrier.

**Assignment/Authorization to release information:**

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, coinsurance and non-covered service amounts on the date of service. I authorize the release of my medical information to my insurance carrier, when necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Bowling Orthopaedics. I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I understand that I may be contacted via any method provided to Bowling Orthopaedics in the attempt to collect a debt. By signing this form, I agree to the above stated terms.

**Financial Policy:**

- Payment for services rendered is due at the time of service
- If you have health insurance, Bowling Orthopaedics will file your insurance for you and apply any payments and adjustments to your account. However, you will remain responsible to pay your copayments, deductibles and co-insurance amounts at the time services are rendered.
- If you do not have health insurance, a minimum deposit of \$ 150.00 is required prior to your visit. At the conclusion of the visit the balance will be due and payable.

By signing this form, I understand and agree to the above policies.

**Medicare Authorization:**

I request that payment of authorized benefits be made on my behalf to Bowling Orthopaedics for any services furnished to me by their practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agent (or other insurance carrier) any information needed to determine those benefits or the benefits payable for related services.

Please keep in mind:

- Final responsibility for payment of services rendered remains with the patient.
- Patients who do not have insurance coverage are required to pay for their visit at the time of service.
- Patients who do have insurance must pay their copayment at the time of the office visit.

By signing this form, I understand and agree to the above policies, including the policy regarding Medicare reimbursement.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_ DOB: \_\_\_\_\_

**Acknowledgement of receipt of Notice of Privacy Practices**

By signing below I am acknowledging that I have been provided with a copy of Bowling Orthopaedics’ Notice of Privacy Practices pursuant to the Health Information Portability and Accountability Act of 1996 (HIPAA).

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Evidence of the authority of the patient’s representative must be attached to the last page of this acknowledgement. If the patient is unable to sign, please document the reason and initial.: \_\_\_\_\_

I agree that Bowling Orthopaedics, PA and affiliated agencies may contact the numbers I have provided and if necessary leave a message. I also authorize to be contacted via email to the address I have provided. Methods of contact may include using pre-recorded / artificial voice messages and/or use of an automated dialing device as applicable. This is often times used for appointment reminders. By checking the box I agree to have read the above disclosure and agree that the creditor may contact me.

I hereby give Bowling Orthopaedics, PA permission to give information about my health and/or medical condition to the person(s) listed below:

| Name  | Relationship |
|-------|--------------|
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

In order for you or anyone else to obtain information from our office about your health and/or medical condition by telephone, the party calling must share a unique and specific patient identifier with our staff. **(Password)**

Patient Identifier: \_\_\_\_\_



Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial \_\_\_\_\_

**Prescription Policy**

Date of Birth: \_\_\_\_\_

The purpose of this policy is to prevent misunderstandings regarding prescription medications you may be prescribed. The medications may be prescribed for pain resulting from an injury or surgical procedure. This policy is to help you and our providers comply with the law regarding controlled pharmaceuticals.

Our office is unable to provide pain medication after business hours and on weekends. Exceptions are made on a case by case basis. **Prescription refill requests require at least 48 hours' notice.** Refills will only be called in to the pharmacy listed unless otherwise notified. Please make the necessary arrangements during our regular office hours. Evidence of altering prescriptions, multiple physicians prescribing, or the use of street drugs will result in dismissal as a patient of Bowling Orthopaedics.

- I will not lose my prescriptions as lost prescriptions will not be replaced
- I will take my medications as prescribed. If I use my medication at a greater rate than prescribed, it will result in me being without medication for a period of time.
- I will not take other medications that may interact with narcotics without first consulting with our providers or their assistants.
- I will not sell, share or permit others to have access to my medications. I will not take someone else's medication.
- I will not drive or operate machinery while on pain medication because it can alter my mental status.
- I will not drink alcohol while taking these medications because combining these drugs with alcohol may cause severe drowsiness, low blood pressure or even death.
- I will report signs of dependence to narcotics, such as taking increased amounts or taking more often than ordered.
- I will submit to blood and/or urine drug screen testing if requested by Bowling Orthopaedics
- I agree to authorize the doctor and the pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, etc. of my medications. I agree to waive any applicable privilege or the right to privacy or confidentiality with respect to these authorizations.
- I will keep all my scheduled appointments. If I need to reschedule my appointment, I will do so a minimum of 24 hours in advance. If I miss an appointment, I will not be able to get a prescription refill and may be charged a \$25.00 "no show" fee.
- If I give permission to someone else to pick up my prescription from the office, a photo ID is required and I am responsible if it is lost, stolen, destroyed or does not reach my possession.

I understand Bowling Orthopaedics may stop prescribing the medications if:

- I do not follow the above policies
- I do not show any improvement in pain or my activity level has not improved
- I develop rapid tolerance or loss of improvement from the treatment
- I develop significant side effects from the medication
- My behavior is inconsistent with the responsibilities outlined above, which may result in being prevented from receiving further care from Bowling Orthopaedics.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Jack W. Bowling MD

Ryan Murphy PA, C

① Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Date of Onset/Accident/Injury/Surgery: \_\_\_\_\_

② Pain level:      0   1   2   3   4   5   6   7   8   9   10  
                         (minimal)    (moderate)    (maximum)

Type of Pain:    Constant [ ]   Intermittent [ ]   Frequent [ ]   Occasional [ ]   Wakes from sleep [ ]

Quality of Pain:   Sharp [ ]   Dull [ ]   Stabbing [ ]   Throbbing [ ]   Aching [ ]   Burning [ ]   Shooting [ ]   Radiating [ ]

Pain worsened by:   Sitting [ ]   Standing [ ]   Walking [ ]   Climbing [ ]   Kneeling [ ]   Bending [ ]   Stairs [ ]   Weight bearing [ ]

Other Symptoms:   Swelling [ ]   Tingling [ ]   Numbness [ ]   Weakness [ ]   Stiffness [ ]   Discoloration [ ]

Pain relieved by:   Rest [ ]   Elevation [ ]   Ice [ ]   Medication [ ]   Other [ ]: \_\_\_\_\_

Current Pain Medications: \_\_\_\_\_

Current Physical Therapy/Exercises: \_\_\_\_\_

Previous Treatments: *(please indicate date and type)*

Injection \_\_\_\_\_ Physical Therapy \_\_\_\_\_ Brace/other \_\_\_\_\_

• ARE YOU CURRENTLY UNDER A CONTRACT WITH PAIN MANAGEMENT?   YES   or   NO

Pain Management Doctor? \_\_\_\_\_

For what medications? \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ Chart# \_\_\_\_\_

**③ Past Medical History: *please indicate any changes since your last visit***

**Cardiac**

- High Blood Pressure
- Heart Attack/MI
- Irregular Heartbeat
- Peripheral Vascular Disease
- DVT / Other
- Atrial Fib
- Congestive Heart Failure

**Kidneys**

- Kidney Failure
- Dialysis
- Kidney Stones
- Burning/ UTI

**Neurological**

- Stroke
- Nerve Damage
- Depression
- Confusion/Dementia
- Other neurological problem
- Anxiety
- Bipolar Disease

**Endocrine**

- Thyroid Problems
- Diabetes
- Type 1 or Type 2
- Other endocrine problem

Do you have any Stents in your legs? Yes or No

**Blood**

- HIV/AIDS
- Hepatitis
- History of blood transfusion
- Other \_\_\_\_\_

**Pulmonary**

- Asthma
- COPD/Emphysema
- TB
- Other \_\_\_\_\_

**Arthritis**

- DJD/Osteoarthritis
- Osteoporosis
- Rheumatoid
- Psoriatic

**Other**

- Fibromyalgia
- Lupus
- Back/Spine History
- Cancer \_\_\_\_\_

**Social History:**

Do you smoke?  yes  no packs per day: \_\_\_\_\_ Do you drink alcohol?  yes  no drinks per day: \_\_\_\_\_

Have you ever smoked?  yes  no If so, when did you quit? \_\_\_\_\_

**④ Review of Systems: *please CIRCLE ALL of the ones you are experiencing today***

**General:** Chills, Fever, Night Sweats, Weight Gain and Weight Loss

**Skin:** Lesions, Rash, and Skin Color Changes

**HEENT:** Headache and Vision Changes

**Neck:** Neck Pain

**Respiratory:** Difficulty Breathing

**Cardiovascular:** Chest Pain, Irregular Heartbeat (Type: \_\_\_\_\_) and Shortness of Breath

**Gastrointestinal:** Jaundice and Stomach Ulcers

**Musculoskeletal:** Decrease Range of Motion, Joint Pain, Joint Redness, Joint Stiffness, Joint Swelling

**Hematology:** Abnormal Bleeding, Anemia, and Blood Transfusion

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ Chart# \_\_\_\_\_

⑤ **Past Surgical History:** *please list all surgeries you have had and/or any changes since your last visit*

Procedure:

Date:

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**Family History:** Have you or anyone in your family experienced a complication with anesthesia?  yes  no

Please describe: \_\_\_\_\_

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ Chart# \_\_\_\_\_

⑥ Medications: *please list all medications you are currently taking with the dosage including any supplements.*

| Medication | Dosage | Frequency |
|------------|--------|-----------|
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Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold Bowling Orthopaedics responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient/guardian: \_\_\_\_\_ Date: \_\_\_\_\_