MERCYHEALTH

PATIENT REGISTRATION FORM

First Name _____ MI____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ ZIP_____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

SS# _____-_____-_____ Sex: M F Email Address: _____

Ethnicity: Hispanic Non-Hispanic Unknown
Race: American Indian and Alaska Native Bi-Racial Middle Eastern Hawaiian/Pacific Islander
Black or African American White/Caucasian Other Unknown

Employed: Y / N PT / FT Employer: _____

Marital Status: M S D W Sep SO Spouse Name_____ Spouse DOB _____

How did you hear about us? _____

Advance Directives: Do you have a Living Will? Yes No Preferred Language _____

Emergency Contact: Name _____Relationship _____Phone (____) _____

If the Patient is NOT the Subscriber (person who carries insurance) please provide additional information requested below:

Primary Insurance: _____Subscriber Name: _____

Relationship: _____DOB: _____

Employed: Y / N PT / FT Subscriber Name of Employer: _____

Secondary Insurance: _____Subscriber Name: _____

Relationship: _____DOB: _____

Employed: Y / N PT / FT Subscriber Name of Employer:_____

Primary Care Physician: _____Address: _____ Phone :(____) _____

Referring Physician: (if applicable) _____ Phone (____) _____

***If you have MEDICARE, please also complete the following questions below**

MEDICARE QUESTIONAIRE

1.) Are you receiving Black Lung Benefits (BL)? Yes No
2.) Are the services to be paid by a government research program? Yes No
3.) Are you entitled to benefits through the Department of Veterans Affairs (DVA)? Yes No
4.) Was the illness/injury due to a work-related accident/condition? Yes No
5.) Are you entitled to Medicare based on Age? Yes No
6.) Are you entitled to Medicare based on Disability? Yes No
7.) Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)? Yes No

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

_____ _____

Signature of Person Responsible Date

MERCYHEALTH

Patient Name: _____

DOB: _____

Communication Release of Information

The Privacy Rule generally requires healthcare providers to take reasonable steps to minimize the Protected Health Information (PHI) requests, usage and disclosure for only what is required to meet the intended need. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in a medical emergency.

_____ **DO NOT PROVIDE health information regarding blood work, appointments, and test results to anyone but me.**

_____ **I give permission to receive my health information regarding normal test results in a voice mail message.**

Authorized Representatives

I give permission for the following people listed to receive the following PHI elements as specified below.

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

___ Appointments ___ Billing ___ Test Results ___Discuss my condition and treatment

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

___ Appointments ___ Billing ___ Test Results ___Discuss my condition and treatment

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

___ Appointments ___ Billing ___ Test Results ___Discuss my condition and treatment

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

___ Appointments ___ Billing ___ Test Results ___Discuss my condition and treatment

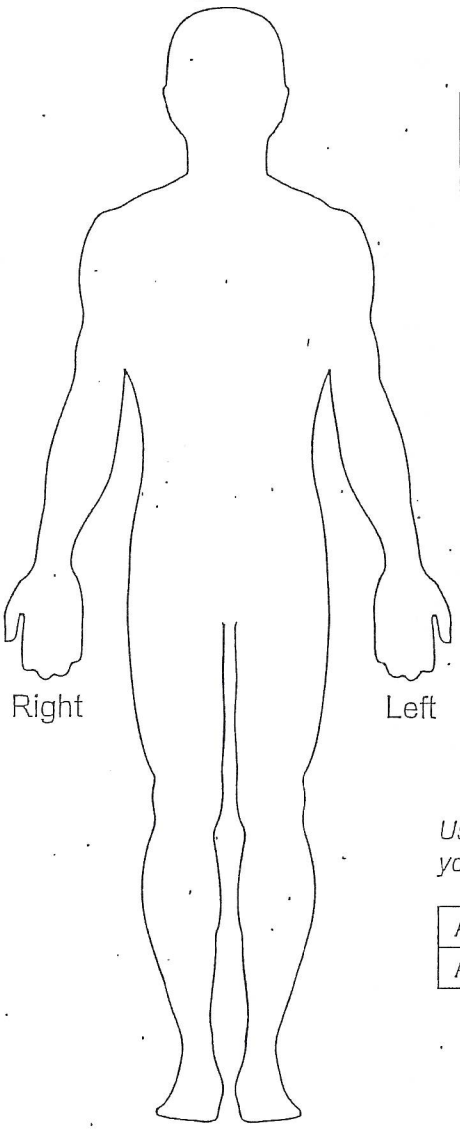
My signature below acknowledges that I provided the information above.

Signature of Patient/Legal Guardian _____ **Date** _____

WELLINGTON®
Orthopaedic & Sports Medicine
A PARTNER OF MERCYHEALTH

Patient Name: _____ Today's Date: _____

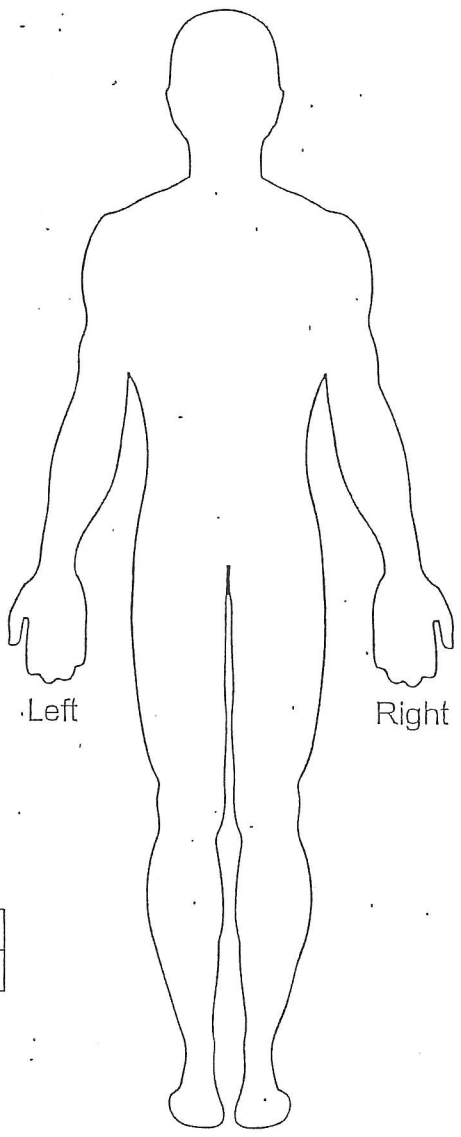
Age: _____ Referring Physician: _____ Family Physician: _____



Where is your pain now?

Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
TOTAL	100	%

Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, neck and back.



Use the body diagrams to show where you feel the following sensations.

Ache	Numbness	Burning	Stabbing
AAA	OOO	XXX	///

What treatments have you had for this problem? *(Check all that apply)*

☐ None ☐ Physical Therapy ☐ Chiropractic ☐ Injections ☐ Pool Therapy
☐ Strengthening ☐ Traction ☐ Acupuncture ☐ TENS ☐ Massage
☐ Brace ☐ Heat/Ice ☐ Therapeutic Ball ☐ Muscle Relaxants ☐ Pain Medications
☐ Anti-Inflammatory (Prescription) ☐ Anti-Inflammatory Over the Counter (Aspirin, Tylenol, Advil, Aleve, etc.)
☐ Other: _____

Have you had any tests for this problem?

☐ X-Ray ☐ MRI ☐ Discography ☐ CT ☐ EMG
☐ CT/Myelogram ☐ Bone Scan ☐ Other *(Please specify)*: _____

MERCYHEALTH

Name:_____ Date:_____

REVIEW OF SYSTEMS	ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING CONDITIONS *(Circle Yes or No)*		If any yes answer, please explain below
General	Recent weight change	No / Yes	
Skin	Skin condition / cancer	No / Yes	
Head, eyes, ears, nose & throat (ENT)	Headaches	No / Yes	
	Dizziness / blacking out	No / Yes	
	Eye or hearing impairment	No / Yes	
	Sinus or throat trouble	No / Yes	
	Nosebleeds	No / Yes	
Neck	Thyroid disease	No / Yes	
	Enlarged glands	No / Yes	
Respiratory	Asthma	No / Yes	
	Difficulty breathing	No / Yes	
	Pleurisy or pneumonia	No / Yes	
Cardiovascular	Chest pain	No / Yes	
	Shortness of breath	No / Yes	
	Heart attack	No / Yes	
	High blood pressure	No / Yes	
	Blood clots in legs or lungs	No / Yes	
	Swelling of feet or legs	No / Yes	
	Poor circulation	No / Yes	
	Irregular heartbeat	No / Yes	
Gastrointestinal (GI)	Ulcer	No / Yes	
	Gallbladder	No / Yes	
	Hepatitis / liver trouble	No / Yes	
	Bleeding with bowel movements	No / Yes	
	Hemorrhoids	No / Yes	
	Hiatal hernia / reflux	No / Yes	
Genitourinary (GU)	Loss of urine / incontinence	No / Yes	
	Frequent urination	No / Yes	
	Burning, painful urination	No / Yes	
	Blood in urine	No / Yes	
	Kidney stones / kidney disease	No / Yes	
Gynecological (GYN)	Bleeding or other problem	No / Yes	
	Breast masses	No / Yes	
Musculoskeletal	Fractures or other injuries	No / Yes	
	Back or neck pain	No / Yes	
Neurological	Seizures or other conditions	No / Yes	
	Neuropathy	No / Yes	
	Stroke	No / Yes	
	Chronic pain	No / Yes	
	Fibromyalgia	No / Yes	
Psychological	Depression or other problems	No / Yes	
Hematological	Blood disorders or cancer	No / Yes	
	Excessive bleeding after surgery/dental work	No / Yes	

Patient Signature:_____ Date:_____