ACTIVE ORTHOPAEDICS, P.C.
Patient Registration

Patient's Full Name: _____ Age:_____ Sex:_____ Birthdate:_____

Address: _____ City:_____ ST:_____ Zip:_____

Home Phone:_____ Cell:_____ Work Phone:_____

Social Security #:_____ Marital Status:_____ Who referred you here? _____

Emergency Contact: _____ Relationship: _____ Phone #:_____

Family Physician: _____ Address: _____

**********EMPLOYMENT**********

Occupation: _____ Employer: _____

Employer Address: _____ City/ST: _____ Phone #:_____

**********SPOUSE/GUARDIAN INFORMATION**********

Name: _____ Relationship: _____ DOB: _____ SSN# _____

Address: _____ City/ST: _____ Phone #: _____

Employer: _____ Address: _____ Work Phone: _____

**********INSURANCE INFORMATION**********

Primary Ins: _____ Secondary: _____

ID#: _____ Group#: _____ ID#:_____ Group#:_____

Insured's name: _____ Insured's name: _____

Insured's D.O.B. _____ Insured's D.O.B. _____

**********WORK RELATED/AUTO ACCIDENTS**********

Is this a work related injury? Yes No Is this a motor vehicle accident injury? Yes No

Date of injury/Accident: _____ File/Claim#: _____

Send claims to: Insurance Company Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Insurance Company Phone: _____ Contact Person: _____

If Work Related: Employer Name & Address: _____

**********PLEASE SIGN BELOW**********

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIM. I ALSO REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGMENT. **IN THE EVENT THAT MY INSURANCE COMPANY DENIES PAYMENT OF A CLAIM IN WHOLE OR PART, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL. COPAY IS DUE AT THE TIME OF SERVICE.**

_____ _____ _____

Patient's Signature or Guardian Relationship to patient Today's date

Name_____ Date_____

Age____ Weight_____ Height_____ Race_____ Language_____ Ethnicity_____

PROBLEM AREA FOR THIS EVALUATION _____

How long has this been a problem? _____

What have you done to alleviate this problem? _____

Tests (XRAY/MRI) performed for this problem? _____ Where? _____

MEDICAL HISTORY:

Please place an (X) before any of the following that apply to you:

___Sleep Apnea
___Immune Deficiency Disorder
___Alcoholism
___Anemia
___Anxiety
___Bleeds easily/bleeding disorder
___Cancer, Tumor
___Depression
___Diabetes
___Epilepsy
___Eye Problem
___Headaches
___Heart Disease
___Hepatitis
___HIV
___High Blood Pressure
___Low Blood Pressure
___Kidney Disease
___Liver Problems
___Lung Disease
___Phlebitis
___Rheumatic Fever
___Stroke
___Tuberculosis
___Thyroid Disease
___Ulcer, Stomach
___Weight Loss
___Weight Gain
___Other _____

HOSPITALIZATION/SURGERY:

List illness or operations & approximate year

1._____
2._____
3._____
4._____

MEDICATIONS:

List all MEDICATION AND DOSAGE with or without a prescription

1._____/_____
2._____/_____
3._____/_____
4._____/_____
5._____/_____
6._____/_____
7._____/_____
8._____/_____

DRUG/FOOD ALLERGIES: Are you allergic to any medications or food? ____NO _____YES

If yes, please list:

_____

SOCIAL HISTORY

_____Married _____ Divorced _____ Single ____Widowed

Occupation: _____

Do you smoke? ___YES ___NO If yes, how many packs/day? _____

Do you drink? ___YES ___NO If yes, how much/day? _____

Any history of drug abuse? ___YES ___NO If yes, what drugs? _____

FAMILY HISTORY: List illnesses of blood relatives

_____ Who: _____

_____ Who: _____

_____ Who _____

PHARMACY NAME/ADDRESS & PHONE

_____

Have you had other orthopedic problems? Fractured any bones? Dislocated any joints? ___YES __NO

If yes, please explain: _____

_____

CERTIFICATE OF AUTHENTICITY:

I hereby certify that the above information is true and correct within the best of my ability?

Signed: _____ Date:_____

ACTIVE ORTHOPAEDICS, P.C.

MICHAEL J. KAPLAN, M.D.
ERIK J. CARLSON, M.D.

MEDICATION AND PRESCIPTION POLICY

- Given the nature of your injury or condition, you should only require narcotic pain medication for a certain amount of time, if at all. It is your responsibility to take your medications as prescribed and according to directions. It is your responsibility to store them legally, safely, and out of reach of others. Every effort on our part will be used to switch you over to a non-narcotic pain medication as soon as your pain level permits. Our office, your pharmacy, and your insurance company will monitor your prescription refills for excessive, abuse, or long-term use.

- If necessary, you will be referred to pain management specialist.

- Failure to seek care with a pain management specialist when referred could result in possible termination of your care.

- **It is your responsibility to call our office for refill requests in a timely manner. The doctor is not in the office every day. Therefore, if you require a refill on your prescription by a certain day, PLEASE make sure you provide a minimum of three business days notice to our office. Refill requests will not be addressed on weekends or after office hours.**

- We do not keep any pain medication in our office.

- **EARLY REFILLS WILL NOT BE HONORED FOR ANY REASON**

DO NOT LOSE YOUR PRESCRIPTION(S)

DO NOT LET OTHERS USE YOUR MEDICATIONS FOR ANY REASON

DO NOT PLACE YOUR MEDICATIONS IN AN UNLABELED CONTAINER

I have read and understand the above medication policy.

Patient's Signature: _____

Printed Name: _____

Date: _____

Notice of Privacy Practices Acknowledgment

Active Orthopaedics, P.C.
1579 Straits Turnpike
Middlebury, CT 06762

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____DOB:_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

ACTIVE ORTHOPAEDICS P.C.

1579 Straits Turnpike
Middlebury, CT 06762
Phone: 203.758.1272 Fax: 203 758.1070

HIPPA RELEASE FORM

Patient Name: _____

HIPPA requires us to have releases signed by our patients for us to speak with family members and other relations regarding medical treatment. Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

Name: _____

Relationship: _____

Telephone #: _____

Name: _____

Relationship: _____

Telephone #: _____

Name: _____

Relationship: _____

Telephone #: _____

I further understand that I give Active Orthopaedics P.C. permission to leave **detailed messages containing specific medical information** on my voice mail or answering machine (including cell phone), I need to give permission to Active Orthopaedics P.C. to do so.

- ☐ Yes
- ☐ No

Consent for Leaving Messages
I consent to information regarding my or my child's (under the age of 18) lab test results or detailed appointment reminder/instruction be left on my voice mail or answering machine (including cell phone).

- ☐ Yes
- ☐ No

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.
This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent must provide written notice to the staff at Active Orthopaedics P.C.

PATIENT SIGNATURE:_____ DATE:_____