

# Denali Orthopedic Surgery, P.C.

## Patient Registration Packet

### Patient Information

Name: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
First MI Last

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Message/Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender (please circle): Female Male

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Marital Status (please circle): Single Married Divorced Widowed

Spouse Name: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Employer Information

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Emergency Contact Information

Primary Contact: \_\_\_\_\_ Phone/Cell:(\_\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Phone/Cell:(\_\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

### How Did You Hear About Us?

- Family or Friend  Referral: \_\_\_\_\_
- Phone Book  Other: \_\_\_\_\_

### Minor Patients (Under Age 18)

The parent or guardian accompanying the minor to the office is responsible for any charges incurred and any payments due at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements for treatment have been made. In the case of multiple guardians (divorce or separation) the financial responsibility becomes that of the guardian who accompanies the patient to their appointment. If insurance coverage is under a guardian not present at the time of service, the information pertaining to that coverage (address, SSN, ID# and group number) is required to bill the insurance. **We WILL NOT bill anyone who is absent at the time of service.**

Parent or Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone (if different from above): (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone:(\_\_\_\_\_) \_\_\_\_\_

Other Parent or Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone (if different from above): (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone:(\_\_\_\_\_) \_\_\_\_\_

**Insurance/Billing Information**

Will this visit be covered under Workers Compensation or Motor Vehicle/Liability Insurance?  YES  NO  
Do you have Insurance?  YES  NO

If YES, please complete insurance information below:

**Primary Insurance Company:** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone Number: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone Number: \_\_\_\_\_

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**Authorizations (Optional)**

I authorize Denali Orthopedic Surgery, P.C. to discuss billing/medical information with the individual below:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I authorize the below individual to be present in the exam room while I am being treated and care is discussed:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I authorize Denali Orthopedic Surgery, P.C. to release medical information to my child's school nurse at:

\_\_\_\_\_  
Name of School (Minors Only)

\_\_\_\_\_  
**Signature** \_\_\_\_\_ **Date**

If signed by someone other than the patient, please state relationship: \_\_\_\_\_

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**Notice of Billing / Collection Policy / Authorization for Treatment / Privacy Practices**

I have been provided a copy of Denali Orthopedic Surgery's financial policy which outlines their billing/collection procedures. I authorize all proceeds from insurance to be assigned to this office where applicable. I confirm that the information I have provided is true to the best of my knowledge. Additionally, I authorize treatment of the named patient contained in this registration packet.

I understand that Denali Orthopedic Surgery, P.C. may share my health information for treatment, billing, and healthcare operations. I have been given a copy of the practice's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Denali Orthopedic Surgery, P.C. has the right to change this notice at any time. I may obtain a current copy by contacting the office, or the Privacy Officer/Practice Manager.

\_\_\_\_\_  
**Signature** \_\_\_\_\_ **Date**

If signed by someone other than the patient, please state relationship: \_\_\_\_\_

# Denali Orthopedic Surgery, P.C.

## Health History Questionnaire

In an effort to serve you better, we request you please provide us with the following information. This information helps us provide you with the best care and treatment possible. Please keep in mind **all information is held strictly confidential**. Thank you for your time.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Reason/Chief Complaint for Consultation: \_ Left \_ Right \_\_\_\_\_  
Date of Injury or Onset: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominate Hand: \_ Left \_ Right  
Family Physician: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

### Patient Present/Past Medical History

Please list any medical conditions (e.g., Heart Disease, Stroke, Cancer, Diabetes, Blood Clots, Ulcers, etc.) you are currently being treated for or have been treated for in the past.

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### Surgical/Fracture History

Type of Surgery/Fracture

Date

_____	_____
_____	_____
_____	_____
_____	_____

Have you or any of your family members ever experienced any problems with anesthesia? \_ Yes \_ No  
(If yes, please indicate problems experienced with anesthesia) \_\_\_\_\_

### Current Medications

(Please list prescription medications, over-the-counter medications, and vitamins)

Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____

### Drug Allergies

Medication _____	Type of Reaction _____
Medication _____	Type of Reaction _____
Medication _____	Type of Reaction _____

Are you allergic to latex products? \_ Yes \_ No

Are your immunizations current? \_ Yes \_ No

### Family Medical History

(List any family history for significant conditions such as Heart Disease, Hypertension/High Blood Pressure, Stroke, Diabetes, Cancer, Rheumatoid Arthritis, etc.)

Father: _____	Deceased	_ Yes
Mother: _____	Deceased	_ Yes
Siblings (s): _____	Deceased	_ Yes

# Social History

**Marital Status:** \_ Married \_ Single \_ Widowed \_ Divorced

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

**Who do you live with?** \_\_\_\_\_

\_ Yes \_ No **Tobacco/Cigarette Use** If yes, packs/times per day? \_\_\_\_\_ Number of years \_\_\_\_\_

\_ Yes \_ No **Pipe/Cigar/Chew Use** If yes, how many times per day? \_\_\_\_\_ Number of years \_\_\_\_\_

\_ Yes \_ No **Alcohol Use Type:** \_ Beer \_ Wine \_ Liquor # of drinks per week \_\_\_\_\_

If yes, do you drink daily? \_ Yes \_ No

\_ Yes \_ No **Marijuana/Cocaine/Other Drug Use Type:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

## Review of Systems

(Indicate any symptoms you have experiences in the last three months)

### Constitutional

YES NO

- Fever
- Chills
- Weight Loss
- Night Sweats

### Neurological

YES NO

- Headaches
- Numbness
- Weakness
- Seizures
- Vertigo/Dizziness
- Lack of Coordination
- Loss of Balance
- Stroke
- Other: \_\_\_\_\_

### Eyes

YES NO

- Glasses/Contacts
- Vision Loss
- Other: \_\_\_\_\_

### Ears/Nose/Throat/Mouth

YES NO

- Hearing Loss/Disorders
- Dentures
- Sore Throat
- Other: \_\_\_\_\_

### Cardiovascular

YES NO

- Chest Pain/Heart Attack
- History of Blood Clots
- Swelling of Ankles/Feet
- Poor Circulation
- Heart Palpitations
- High Blood Pressure
- Heart Disease
- Other: \_\_\_\_\_

### Respiratory

YES NO

- Asthma
- Shortness of Breath
- Recent Cold/Flu
- Coughing up Blood
- Other: \_\_\_\_\_

### Gastrointestinal

YES NO

- Indigestion
- Ulcers
- Black/Bloody Stools
- Liver Disease/Hepatitis
- Other: \_\_\_\_\_

### Genitourinary

YES NO

- Painful Urination
- Urgency to Urinate
- Blood in Urine
- Decrease in Urine Flow
- Urinary Infection
- Other: \_\_\_\_\_

### Women Only

- Currently Pregnant
- Date of Last Menstrual Period? \_\_\_\_\_

### Musculoskeletal

YES NO

- Fracture/Broken Bone
- Joint Pain/Swelling
- Muscle Weakness
- Gout
- Arthritis
- Musculoskeletal Pain- Location? \_\_\_\_\_
- Other: \_\_\_\_\_

### Skin

YES NO

- Eczema/Psoriasis
- Rash
- Ulcer
- Other: \_\_\_\_\_

### Psychiatric

YES NO

- Depression
- Anxiety
- Mental Illness
- Other: \_\_\_\_\_

### Allergy/Immunologic

YES NO

- Poor Healing
- Persistent infection
- Exposure to HIV
- Exposure to TB
- Exposure to Hepatitis
- Other: \_\_\_\_\_

### Hematologic/Lymphatic

YES NO

- Swollen Glands/Nodes
- Anemia
- Bleeding Disorder
- Blood Transfusion(s)
- Other: \_\_\_\_\_

### Endocrine

YES NO

- Cold/Heat Intolerance
- Diabetes
- Thyroid Disorder
- Other: \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature (Parent if Minor Patient)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**