Paul Phillips III, MD
Patient Registration

Patient Name:_____ Date of Birth:_____ SSN:_____

Mailing Address:_____ City:_____ State:____ Zip:_____

Email:_____ Cell Phone:_____

Home Phone:_____ Work Phone:_____

Consent to text? Yes ☐ No ☐

Pharmacy Name and Location:_____

Emergency Contact Name:_____ Phone:_____

Insurance Company(s):_____ Member ID:_____

Secondary _____ Member ID:_____

Responsible Party name if NOT SELF:_____ Relationship:_____

Personal Are you: Male☐ Female☐ | Single☐ Married☐ Divorced☐ Separated☐ Widowed

White ☐ Hispanic ☐ African American ☐ Asian☐ Native American☐ Multi-ethnic☐

Preferred Language:_____

Employment Are you employed? Yes ☐ No ☐ Retired ☐ Employer:_____

Treatment & Financial Authorizations

I consent to and authorize examination and treatment for this and all the following physician visits until revoked in writing. I authorize to release any medical information necessary to process insurance billing claims. I authorize payment and assignment of insurance benefits to the doctor's office.
I am personally responsible for supplying accurate and current insurance information.
I understand I am financially responsible for all the charges, deductibles and copays not covered by my insurance. I will receive an EOB (Explanation of Benefits) from my insurance company, I agree to pay any amounts indicated by the insurance company as patient liability amounts. I will receive a bill from POA regarding these amounts and agree to pay upon receipt of bill. I further understand that should my account become delinquent, it could be turned over to a collection agency with additional collection and /or attorney fees. I acknowledge that I have had an opportunity to review the HIPPA Notice of Privacy Practices.
I authorize a photo copy of this statement to serve as an original.
I authorize PHILLIPS ORHTHOPEDIC ASSOCIATES to obtain my medication list electronically.
I understand there will be a $30 fee for any work limitation paperwork. (ex. FMLA, short term disability)
I understand that if a Lawyer on my (patient's) behalf request any records, billing statements, etc. there is a fee for PHILLIPS ORHTOPEDIC ASSOCIATES.

Signature:_____ **Date:**_____

Patient Medical History

Patient Name:_____

Social History

Do you currently or have ever used tobacco products in the last 25 years? Yes ☐ No ☐

If yes, what type? Cigarette ☐ Chewing Tobacco/Snuff ☐ E-Cigarette ☐ Cigar ☐

Amount used daily? _____ Date if you stopped using tobacco products:_____

Do you consume alcoholic beverages? Yes ☐ No ☐ Number of drinks daily:_____

Do you have a history of alcoholism? Yes ☐ No ☐

Family Medical History (i.e.: cancer, diabetes, stroke, hypertension, etc.)

Father deceased? ☐Yes ☐No Mother deceased? ☐Yes ☐No

Father		Mother	
Medical Problem	Age Diagnosed	Medical Problem	Age Diagnosed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications: (If able, please have a list of medications and we can make a copy)

List the name of prescribed/over the counter medication/vitamins you are taking, dosage, and how many per day.

Name	Dosage	#per day	Name	Dosage	#per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies & Reaction

Medication	Reaction		
_____	_____	Mild ☐ Moderate ☐ Severe ☐	Have you ever had a reaction to any kind of metal? (nickel, etc.)
_____	_____	Mild ☐ Moderate ☐ Severe ☐	Yes ☐ No ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐	Reaction: _____

Allergic to LATEX? Yes ☐ No ☐

(If you need more space for medications and allergies write on the back of this page please. Thanks)

Notice of Privacy for Our Office

Your medical record is called Protected Health Information (PHI) under Federal Law 104-191-The Health Insurance & Patient Accountability Act of 7996 (HIPPA-1196). As of March 1, 2003, all medical practices are required by law to notify you of your privacy rights, and we will post any changes to these rights on the examination room bulletin board.

Use of Protected Health Information with your authorization.

By signing the authorization to be treated on our "Patient registration" you agree that your PHI May be used or disclosed by our office staff for the purpose of Treatment, Payment, health care Operations (TPO), or judicial proceedings and that we call you byname in our waiting room. You also may have authorized a release of your PHI by written statement from your employer, attorney, or insurance carrier. Your PHI may be required for our business records, our computer/billing systems, pharmacies, other physicians, laboratories, your employer, or therapists before they will process our request for TPO. You may revoke any authorization, provided we receive it in writing.

What we mean by:

Treatment- other treating personnel, pharmacists, testing facilities.
Payment- for billing and electronic records your diagnosis and treatment dates are disclosed.
Health care operations-compliance audits, public health, office administration or contractual requests.
Judicial proceedings- any court orders, subpoenas, legal audits, or laws demand.

Use of Your Protected Health Information Without Your Authorization

Your PHI may be disclosed as required by law, for public health activities, victims of abuse, health and oversight proceedings, law enforcement, judicial and administrative proceedings, funeral homes, research purposes, or specialized governments functions. In such cases we will release information only if we have received a written request with the documentation that the PHI disclosed is expressly authorized by the order.

What we mean by:

Law- if the law requires we will notify you such disclosures
Public health activities- FDA, communicable disease, work related injury, instances of abuse or neglect.
Health and Oversight- a legal oversight agency for any investigation in which you are not involved.
Law Enforcement- properly issued subpoena, warrant, court order, or legal summons.

Disclosure of Protected Health Information Requiring your Authorization

Our office does not E-mail information, unless you request it in writing. We will not disclose your PHI to family member, personal representatives or guardians unless you request it. In an emergency we may disclose only relevant information if in our professional judgement it is in your best interest. You may request that we modify or do not use or disclose any or part of your PHI in order to carry out treatment, payment or health care operations. This right to restrict does not extend to disclosures as required by law. You may inspect or request of your PHI (in writing) to be sent to you or an alternative location or by alternative means. Our office has the right or explanation of the records. The records shall be sent within 30 days from receipt of the written request and payment. If these copies can not be sent within 30 days we will notify.

I authorize the following people to unlimited access to my PHI, any and all of my medical records: (spouse, parent, guardian, children, ect.)

_____	_____	_____
Print name	Relationship	Phone number
_____	_____	_____
Print name	Relationship	Phone number

I have reviewed this notice of Privacy Practices and understand the address location and contact information for the complete HIPPA-1996, and the Privacy Officer for this office is available upon my request, and also that compliance complaints can be made to the Department of Health and Human Services.

Signature:_____ **Date:_____**

Patient Medical History

Patient Name:_____ Referred By (if any):_____

Weight:_____ Height:_____ Injury work related? Yes ☐ No ☐

Date of Injury:_____ (We do not accept Worker's Compensation)

Primary Care Physician (**First and last name**):_____ Located:_____

Cardiologist (**First and last name**):_____ Located:_____

Please check any surgeries you have had

☐ Cancer Surgery-Location_____ ☐ Carotid Endarterectomy ☐ Hysterectomy
☐ Kidney Stone Removal ☐ Thyroidectomy ☐ Ovaries Removed ☐ Prostate Removed
☐ Angioplasty ☐ Appendectomy ☐ Tubal Ligation ☐ Cardiac Bypass ☐ Gallbladder
☐ Hemorrhoidectomy ☐ Colon (Bowel Resection) ☐ Cardiac Stents- Year_____ ☐ Stents
☐ Cataract Removal- RT LT ☐ Breast Mastectomy RT LT ☐ Hernia Repair- Type_____
☐ Kidney Removed ☐ Tonsillectomy/Adenoidectomy ☐ Plastic Surgery- Type_____
☐ TURP ☐ Abdominal Aorta/ Aneurism Repair Other:_____

Please check any Orthopedic Surgeries

☐ Shoulder ☐ RT ☐ LT Type_____ Year_____ ☐ Knee ☐ RT ☐ LT Type_____ Year_____
☐ Ankle ☐ RT ☐ LT Type_____ Year_____ ☐ Foot ☐ RT ☐ LT Type_____ Year_____
☐ Wrist ☐ RT ☐ LT Type_____ Year_____ ☐ Hand ☐ RT ☐ LT Type_____ Year_____
☐ Hip ☐ RT ☐ LT Type_____ Year_____ ☐ Elbow ☐ RT ☐ LT Type_____ Year_____
☐ Back ☐ RT ☐ LT Type_____ Year_____ ☐ Neck ☐ RT ☐ LT Type_____ Year_____

Do you have a history of or currently being treated for the following:

☐Alzheimer's	☐Depression	☐High Blood Pressure	☐Osteopenia
☐A-Fib	☐Dementia	☐High Cholesterol	☐Osteoporosis
☐Anemia	☐Diverticulosis	☐High Triglycerides	☐Parkinson's Disease
☐Anxiety	☐DVT (blood clot)	☐HIV/AIDS	☐Pacemaker/Defibrillator
☐Asthma	☐Eczema	☐Hiatal Hernia	☐Psoriasis
☐Blood Disorder	☐Environmental Allergies	☐IBS	☐Rheumatoid Arthritis
☐Cancer-Located_____	☐Fibromyalgia	☐Kidney Stone	☐Seizures
☐Carotid Artery Disease	☐GERD	☐Macular Degeneration	☐Sleep Apnea
☐ Colitis	☐Glaucoma	☐Metal	☐Stomach Ulcer
☐Congestive Heart Failure	☐Gout	☐Migraines	☐Thyroid Disorder Hypo/Hyper
☐COPD/Emphysema	☐Heart Arrhythmia	☐ Mitral Valve Prolapse	☐Tuberculosis
☐Coronary Artery Disease	☐Heart Attack	☐Neuropathy	☐Urinary Tract Infection
☐CVA (Stroke)	☐Hepatitis A B C	☐Osteoarthritis	☐ MRSA-Located_____
☐Diabetes			Year_____

Have you received Pneumonia Vaccine? Yes ☐ No ☐ If so, when? _____
Have you received a Flu shot? Yes ☐ No ☐ If so, when? _____