Cedar Valley Medical Specialists, P.C.

REGISTRATION FORM

(PLEASE PRINT)

Today's Date: _____

Your Pharmacy: _____

Address: _____

Patient Information (☐ VALIDATED ID ☐ PHOTO ID REFUSED ☐ NO PHOTO ID AVAILABLE)

Last name:	First:	MI:	Sex: ☐ M ☐ F
Nickname:	Birth date:	Age:	Soc. Sec. #:

Marital status:
☐ Single
☐ Married
☐ Divorced
☐ Legally Separated
☐ Widowed

Primary Language:
☐ English
☐ Spanish
☐ Bosnian
☐ Other _____

Ethnicity:
☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Declined
☐ Unknown

Race: _____
01 = Black, African American
02 = Asian
03 = White
08 = American Indian, Alaska Native
09 = Native Hawaiian, Other Pacific Islander
98 = Unknown
99 = Declined

Address:	PO Box:	City:	State:	ZIP Code:
Home phone: ( )	Cell Phone: ( )	Email Address:		
Referred by:	Family Doctor:			
Emergency Contact Name:	Relationship:	Phone: ( )		

Student Information: ☐ Not a Student ☐ Yes if yes, ☐ full-time ☐ part-time

College Name (If attending):

Employment Information: *(If employed fill out below)* Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐

Occupation:	Employer:	Employer phone:
Spouse's Name:	Employer:	

Who will be responsible for your account? ☐ **Self** (if self, skip to next section) ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Other**

Name:	Soc. Sec.#	Phone:	
Address (if different):	City:	State:	Zip Code:
Employer:	Business Phone:		

Health Insurance Information (Please give your insurance card to the receptionist.)

Primary Insurance:

Insurance Company Name:	Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:	Policy Holders S.S.#:
Insured's Employer:	Relationship to Patient:	

Secondary Insurance:

Insurance Company Name:	Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:	Policy Holders S.S.#:
Insured's Employer:	Relationship to Patient:	

If Patient is under 18 years of age: *(and you have not provided the following information in the Health Insurance Section)*

Father's Name:		Mother's Name:	
Address:	Phone:	Address:	Phone:
Employer:		Employer:	

If this is a result of an accident or injury, please answer the following questions & complete accident/injury form.

Date of Accident or Injury:	Brief Description of Injury:

- I authorize you to give me reasonable and proper medical care by today's standards.
- I authorize Cedar Valley Medical Specialist's P.C. to release any medical information necessary to process my claim.
- I authorize payment of medical benefits to Cedar Valley Medical Specialist's P.C.
- I understand that I am responsible for any balance due on my account.
- I authorize that a copy of this information to be as valid as the original.

Signature: _____ Date: _____

Cedar Valley Medical SPECIALISTS, P.C. *We specialize in you.*™

GBG – Department of Orthopedics

Medical History Questionnaire

Name: _____ **Date:** _____

□ Male □ Female Age: _____ Height: _____ Weight: _____

Dominant Hand: □ Right □ Left

What problem are you seeing the doctor for today?

□ Right □ Left □ Both

□ Hip	□ Shoulder
□ Thigh	□ Arm
□ Knee	□ Elbow
□ Calf	□ Forearm
□ Ankle	□ Wrist
□ Foot	□ Hand
□ Toes B 2 3 4 5	□ Finger B 2 3 4 5

When did your problem start: ____/____/____ or # _____ □ Days □ Weeks □ Months □ Years

Was this problem a result of an injury or accident? □ No □ Yes

If yes, date of accident ____/____/____

Did your accident occur at: □ Work □ Motor Vehicle □ Sports □ Other _____

***Pain Scale** 1-10 (10 being the worst) _____ ***Is your pain:** □ Constant □ Comes & Goes □ Sharp □ Stabbing □ Dull □ Throbbing □ Aching □ Burning

***Do you have:** □ Numbness □ Tingling □ Weakness □ Swelling □ Bruising □ Stiffness

***What makes the problem BETTER:** _____

***What makes the problem WORSE:** _____

Prior treatment for this problem? □ No □ Yes When _____

If yes, what doctor treated you? _____

Have you had any: □ Physical Therapy □ Cortisone Injection □ Xrays □ MRI □ CT Scan □ Nerve Testing (NCV/EMG) where: _____

Have you had SURGERY for this problem before: □ No □ Yes – Date: ____/____/____

If yes, what type of surgery: _____

I GIVE PERMISSION TO RELEASE HEALTH INFORMATION TO THE FOLLOWING PEOPLE (Ex. FAMILY MEMBERS/FRIENDS): _____

SIGNED (ADULT): _____

GBG – Department of Orthopedics

Medical History Questionnaire

Name: _____ **Date:** _____

Signs and/or symptoms you may be experiencing or have experienced recently.

General Health □ Excellent □ Good □ Fair □ Poor

Yes	No		Yes	No	
□	□	Weight Loss	□	□	Blood Clots
□	□	Hearing Loss	□	□	Stroke
□	□	Double Vision	□	□	Arthritis
□	□	Difficulty Swallowing	□	□	Rheumatoid Arthritis
□	□	Shortness of Breath	□	□	Gout
□	□	Chest Pain	□	□	Osteoporosis
□	□	Back Pain	□	□	High Blood Pressure/Hypertension
□	□	Skin Disease/Rashes	□	□	Heart Disease
□	□	Headaches	□	□	COPD
□	□	Seizures	□	□	Asthma
□	□	Anxiety	□	□	Sleep Apnea
□	□	Bladder Infections or Frequent Urination	□	□	Diabetes
□	□	Anemia/Blood Disease	□	□	Kidney Disease
□	□	Hemophilia	□	□	Hepatitis
□	□	HIV/AIDS	□	□	Cancer: _____

Allergies

Yes	No	
□	□	Penicillin
□	□	Sulfa
□	□	Codeine
□	□	IVP Dye
□	□	Metal
□	□	Morphine

Other: _____

_____

Previous Surgery

Yes	No	
□	□	Back
□	□	Tonsils
□	□	Appendix
□	□	Gallbladder
□	□	Hernia
□	□	Hysterectomy
□	□	Tubal Ligation
□	□	Heart Surgery
□	□	Total Knee
□	□	Total Hip
□	□	Carpal Tunnel
□	□	Rotator Cuff Surgery

Other _____

Family History

Yes	No	
□	□	Cardiac Issues
□	□	Diabetes
□	□	Hypertension
□	□	Rheumatoid Arthritis
□	□	Cancer
□	□	Blood Clots

* Indicate which relative has history of illness _____

_____

_____

_____

Current Medications: _____

_____

Social History

Smoking: □ No □ Yes

Alcohol: □ No □ Yes □ Frequently

Martial Status: □ Married □ Single □ Divorced □Widowed

Work Status: □ Regular □ Light Duty □ Disabled □ Retired □ Student

Occupation/Employer: _____

Cedar Valley Medical Specialists, P.C.
Patient Communication Form for Privacy Practices

Office/Specialty:_____ Date:_____

Our office will make an effort to notify you of your test/lab/procedure/etc. results, if necessary. You may instruct Cedar Valley Medical Specialists, P.C. as to the method of communication and who may and/or may not receive these communications.

Please Mark the Best Method of Communication

☐ Home Phone _____

☐ Cell Phone _____

☐ Work Phone _____

☐ Mailing Address _____

_____

_____

☐ Email Address _____

I give my permission for the following **TO RECEIVE** my test/lab/procedure/etc. results, if necessary.

(The person/s below will only receive test results if patient is unavailable or unable to be reached).

Spouse (full name) _____ (Phone) _____

Child (full name) _____ (Phone) _____

Friend (full name) _____ (Phone) _____

Parent (full name) _____ (Phone) _____

Other (full name) _____ (Phone) _____

DO NOT give my personal Health Information to the following named person/persons.

(full name) _____ (Phone) _____

(full name) _____ (Phone) _____

I hereby acknowledge that I have been informed, that I may receive a copy of Cedar Valley Medical Specialists, P.C.'s Notice of Privacy Practices upon request.

☐ **Copy Provided** ☐ **I do not want a copy**

_____ _____ _____

Signature (Patient or Guardian) **Patient Printed Name** **Patient Date of Birth**

_____

Guardian's relationship to patient