

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: <input type="checkbox"/> M <input type="checkbox"/> F
Nickname:		Birth date:	Age:	Soc. Sec. #:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Bosnian <input type="checkbox"/> Other _____	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Declined <input type="checkbox"/> 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: <input type="checkbox"/> Not a Student <input type="checkbox"/> Yes if yes, <input type="checkbox"/> full-time <input type="checkbox"/> part-time				
College Name (If attending):				
Employment Information: (If employed fill out below) Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed <input type="checkbox"/>				
Occupation:	Employer:		Employer phone:	
Spouse's Name:	Employer:			
Who will be responsible for your account? <input type="checkbox"/> Self (if self, skip to next section) <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> 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: _____



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: _____

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

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

Allergies

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | IVP Dye |
| <input type="checkbox"/> | <input type="checkbox"/> | Metal |
| <input type="checkbox"/> | <input type="checkbox"/> | Morphine |
- Other: _____

Previous Surgery

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Back |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsils |
| <input type="checkbox"/> | <input type="checkbox"/> | Appendix |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hysterectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | Tubal Ligation |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Total Knee |
| <input type="checkbox"/> | <input type="checkbox"/> | Total Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | Carpal Tunnel |
| <input type="checkbox"/> | <input type="checkbox"/> | Rotator Cuff Surgery |
- Other _____

Family History

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Issues |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots |
- * Indicate which relative has history of illness _____

Current Medications: _____

Social History

- Smoking: No Yes
Alcohol: No Yes Frequently
Marital 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