



PATIENT REGISTRATION

DATE
PATIENT'S FULL NAME AGE SEX D.O.B.
ADDRESS CITY ST ZIP
HOME PHONE CELL PHONE WORK PHONE
MARITAL STATUS
OCCUPATION EMPLOYER
EMPLOYER ADDRESS

FAMILY PHYSICIAN ADDRESS &/OR PHONE#

REFERRING PHYSICIAN ADDRESS &/OR PHONE#

\*\*\*\*\*RESPONSIBLE BILLING PARTY\*\*\*\*\*

NAME RELATIONSHIP
ADDRESS PHONE
EMPLOYER WORK PHONE

\*\*\*\*\*INSURANCE INFORMATION\*\*\*\*\*

PRIMARY INS. SECONDARY INS.
GROUP # I.D. # GROUP # I.D.#
INSURED'S NAME INSURED'S NAME
INSURED'S D.O.B. INSURED'S D.O.B.

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

DATE OF INJURY/ACCIDENT FILE/CLAIM #
SEND CLAIMS TO: INSURANCE COMPANY NAME
ADDRESS CITY STATE ZIP
INSURANCE COMPANY PHONE CONTACT PERSON
IF WORK RELATED: EMPLOYER AND ADDRESS

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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 ASSIGNMENT.

Responsible Party Signature Relationship Date



## Patient Information Form & Medical History

This form asks important information that we need to document for medical, legal, and insurance purposes. All information is confidential and kept as part of the medical chart in this office.

Date: \_\_\_/\_\_\_/\_\_\_\_\_ Primary Care MD: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Age \_\_\_\_\_  Female  Male Height \_\_\_' / \_\_\_\_\_" Weight \_\_\_\_\_ lbs.

Did you bring x-rays or MRI films with you today?  Yes  No

Who requested that you visit this office? \_\_\_\_\_ or  Self – Referral?

May we send a letter to the referring physician and / or your primary care M.D.?  Yes  No

What body part(s) is/are involved? (Right / left / both) \_\_\_\_\_

Can you please describe the nature of your problems?

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Have you had a prior problem with this same Orthopaedic condition in the past? (explain below if yes)

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How long has this problem been present? \_\_\_\_\_

Check the ONE box which best fits how your problem started. (Use as much space to the right as needed.)

**NO INJURY (for example, arthritis pain)** (Onset was:  Gradual or  Sudden)

Why do you think it started? \_\_\_\_\_

**AUTO ACCIDENT**

Date \_\_\_\_\_ Where and How did it Happen? \_\_\_\_\_

**WORK RELATED**

Date \_\_\_\_\_ Where and How did it Happen? \_\_\_\_\_

**INJURY (other than an auto accident or work injury)**

Date \_\_\_\_\_ Where and How did it Happen? \_\_\_\_\_

**The pain or problem is:**  Constant  Comes and goes (Intermittent)

Severity of pain  None  Mild  Moderate  Severe  Extremely severe  Incapacitating/ worst pain in your life

Patient Printed Name: \_\_\_\_\_ Page 1 of 3

What is the Quality of the pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning  Other: \_\_\_\_\_

Are there associated symptoms?  Swelling  Numbness  Weakness  Redness  Other: \_\_\_\_\_

Since your problem started, is it:  Getting Better  Getting Worse  Unchanged

What makes your symptoms worse?  Activity  Exercise  Work  Other: \_\_\_\_\_

Does anything make you feel better?  Rest  Heat Ice  Elevation  Other: \_\_\_\_\_

**Have you tried any of the following for this problem?**

Brace  Cane  Crutches  Walker  Orthotics / prescription shoes

Medications / Other \_\_\_\_\_

Have you tried physical therapy for this problem? If so, how recently? \_\_\_\_\_

Have you ever had any **steroid (cortisone) injections** for this problem? If so, how recently?

Have you ever had any **Synvisc, Hyalgan, Supartz, or Euflexxa** injections for this problem?

If so, how recently? \_\_\_\_\_

**ARE YOU A DIABETIC?**  Yes  No

**IF DIABETIC, CURRENT TREATMENT:**  Insulin  Oral Medications  Diet  None

**ARE YOU ALLERGIC TO ANY MEDICATIONS?** If so, what happens? \_\_\_\_\_

**(Please check any that apply, or mark None)**

	None	Year	Explain	Details/Comments
<input type="checkbox"/> Weight loss <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Fever <input type="checkbox"/> Cancer	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Double Vision <input type="checkbox"/> Cataract <input type="checkbox"/> Blindness	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ringing in Ears	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart condition <input type="checkbox"/> Blood clots	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Short of Breath <input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Blood in Stool	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Pain with Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney disease	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Rash <input type="checkbox"/> Lumps <input type="checkbox"/> Blisters	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Balance Problem <input type="checkbox"/> Headaches	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Depression <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Other psychiatric illness	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia <input type="checkbox"/> Other (describe)	<input type="checkbox"/>	_____	_____	_____

**HAVE YOU TAKEN ANY OF THE FOLLOWING FOR THIS PROBLEM: (Circle all that apply)**

Advil Ibuprofen/Motrin Lodine Naprosyn Tylenol Ultram/tramadol Celebrex Mobic Aspirin

How long have you taken them? \_\_\_\_\_

**Patient Printed Name:** \_\_\_\_\_

WHAT OTHER MEDICATIONS DO YOU TAKE? (If you have a separate list, we can copy it.)

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PAST SURGICAL HISTORY: What operations have you had and in what years? None

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Have you ever had a reaction to anesthesia?  Yes No

If yes, please elaborate: \_\_\_\_\_

Have you ever had a blood transfusion?  Yes No

Did you have any problems with it? \_\_\_\_\_

FAMILY HISTORY: Have any direct relatives had any of the following disorders?

Diabetes  High Blood Pressure  Heart disease  Arthritis  Cancer

Any direct relative with the same Orthopaedic condition you are being seen for today?

\_\_\_\_\_

If direct blood relatives are deceased, can you please describe the cause of death (e.g., mother, father, siblings): \_\_\_\_\_

Do you currently use tobacco?  None  Yes : Packs per day \_\_\_\_\_

Used to smoke, but stopped \_\_\_\_\_ years ago.

Alcohol use?  None  Yes: How often? \_\_\_\_\_

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

Employer: \_\_\_\_\_

Are you currently working? Yes  No : If **no**, how long have you been off work? \_\_\_\_\_

If working, can you please describe what's involved? (e.g., heavy lifting, desk work, etc.): \_\_\_\_\_

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FOR WORKMAN'S COMPENSATION CASES ONLY: WC CLAIM #: \_\_\_\_\_

Date of injury: \_\_\_\_\_ First date of disability: \_\_\_\_\_ Last date worked: \_\_\_\_\_

If out of work now, who has taken you out of work? \_\_\_\_\_

## LEGAL INFORMATION

Do you have any current or pending litigation involving this problem for which we are seeing you today? Yes No

If so, should we expect requests for information from any parties involved? \_\_\_\_\_

\* Everything I have answered is true and correct to the best of my knowledge. I understand that this is a confidential record of my medical history and will be kept in my chart. *Information contained here will not be released without my authorization to do so.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

**SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, NOTICE OF QUALITY IMPROVEMENT STUDY**

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Orthopaedics New England, P.C. for services furnished by Orthopaedics New England, P.C. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer or agency shown. Orthopaedics New England, P.C. accepts the Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2. **PARTICIPATING INSURANCE AND RELEASE OF INFORMATION:** I understand that Orthopaedics New England, P.C. may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. Orthopaedics New England, P.C. may also tell my health plan and/or referring physician about a treatment I am going to receive to obtain prior approval or to determine whether my plan will cover the treatment, to facilitate payment, or the like.
3. **NON-PARTICIPATING WITH PATIENT'S INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to be by Orthopaedics New England, P.C. if I belong to a plan that Orthopaedics New England, P.C. does not participate with.
4. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with Orthopaedics New England, P.C. to obtain necessary healthcare service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Orthopaedics New England, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Orthopaedics New England, P.C. for payment.
6. **APPOINTMENT CANCELLATION:** We request that at least 24 hour notice be given if you are unable to keep your scheduled appointment. Cancellations with less than 24 hr notice may be billed \$25 per occurrence.
7. **FINANCE CHARGES:** I agree to pay a finance charge of 1% per month, compounded, for any balance I am responsible for which is over 30 days old. I also agree to pay for any returned check fees incurred by Orthopaedics New England, P.C.  
I also agree that if I am the parent/guardian bringing a child in for treatment that I am responsible for all fees incurred by the child.  
If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.  
Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Orthopaedics New England, P.C. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Orthopaedics New England, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
8. **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Orthopaedics New England, P.C. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified or changed in any way.
9. **NOTICE OF QUALITY IMPROVEMENT STUDY:** Dr. Keggi and Dr. Kennon are committed to promoting the scientific basis for the practice of medicine. Orthopaedics New England, P.C. reviews patient results, surgical techniques, the effects of treatment and other measures. Your signature below indicates you understand that your information & results may be reviewed for scientific purposes. Any distribution or discussion of such information outside of Orthopaedics New England, P.C., whether for publication or presentation is done in a manner that removes your name and any other identifying information in order to protect your privacy.

**PATIENT SIGNATURE** \_\_\_\_\_

**SIGNATURE OF PATIENT'S REPRESENTATIVE** \_\_\_\_\_

**PATIENT NAME (PRINT)** \_\_\_\_\_ **DATE** \_\_\_\_\_

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**For Office Use Only**

To be completed by practice if unable to obtain written acknowledgement from the patient

- \_\_\_\_\_ Patient refused or declined to sign this written acknowledgement
- \_\_\_\_\_ Patient could not understand request to sign written acknowledgment
- \_\_\_\_\_ Other reason (please specify)

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICATION POLICY

### POLICY:

Medications affect the way your body and mind function. Every medication, whether prescribed, over the counter or “natural”, changes your chemistry, at least temporarily, or may have permanent harmful effects. The treatment we have recommended aims to balance many factors including your preferences and concerns, the severity of your condition and symptoms, the consequences of no treatment, the risks and benefits of other treatments, and more. Please ask any and all questions about your treatment and provide us with as much information as possible so we may determine the best course of treatment with you.

**We may prescribe for you a new medication or recommend that you try an over-the-counter (OTC) product as part of your treatment. It is vital for your safety that you follow all directions closely that come from the pharmacy, are printed on the package or insert, or are on the container. Always consider the following information:**

**Call your family physician** or Primary Care Provider (PCP) to let them know of the new medication. He or she may modify our recommendation or recommend against the new medication entirely based on his or her knowing your history. Please inform us immediately of any such changes so we can update our records.

**Tell the pharmacist ALL of the medications and supplements you take.** This may slow your visit to the pharmacy, but will reduce the possibility of a drug interaction which could be dangerous.

**Any medication can have unpredicted side effects** or may make you feel poorly. The first time (or first few times) you take a new medication, you should do so in a safe environment where you have access to help if needed.

**Never drive a vehicle** or undertake any activity that requires your full attention when taking a new medication until you understand its effects, if any, upon you.

### Tylenol™ (Acetaminophen, APAP)

Never take more than 4000 milligrams (4 gram) of this medication in a 24 hour period. Eight (8) Extra-Strength Tylenol™ tablets (500 milligrams each) equals 4000 milligrams. Twelve (12) Regular Strength Tylenol™ tablets (325 mg each) equals 3900 milligrams. Do not consume alcohol when taking Tylenol as this can cause severe or fatal liver damage.

MANY OTC and PRESCRIPTION PRODUCTS CONTAIN TYLENOL™. You must be aware of all the contents of all the medications you take in order not to exceed the limit of 4000 milligrams from all sources in a 24 hour period.

### Narcotic Pain Medications

Some names include Percocet™, Vicoden™, Percodan™, Lortab™, Tylenol™ #3, Darvocet™, Darvon™, Propoxyphene, Dilaudid™, Oxycodone, Oxycontin™, Hydrocodone, Codeine, Hydromorphone, Morphine, MS Contin™, Methadone, Fentanyl™ patch and many others.

Many of these also contain Tylenol™ (see above).

Never drive a vehicle or undertake any activity that requires your full attention when taking a narcotic medication – even if you “feel fine” or are “used to it”. You may harm yourself or others.

Never mix narcotic medications with the use of sedatives or alcohol. The combined effect can be unpredictable and fatal.

### Anti-Inflammatory Medications (NSAID's)

Some names include Ibuprofen (Advil™, Motrin™, Nuprin™), Naproxen (Naprosyn™, Aleve™, Anaprox™), Celebrex™, Arthrotec™, Diclofenac (Cataflam™) (Voltaren™), Diflunisal (Dolobid™, Etodolac, Fenoprofen, Flurbiprofen (Ansaid™), Indomethacin, Ketoprofen (Oruvail™), Ketorlac (Toradol™), Meclofenamate, Meloxicam (Mobic™), Nabumetone (Relafen™), Oxaprozin (Daypro™), Piroxicam (Feldene™), Salsalate, Sulindac (Clinoril™), Tolmetin and others. Ibuprofen is included in many OTC preparations as well.

Aspirin is a related medication.

You should only take one of these medications in a single day, unless otherwise, specifically directed by us or your family doctor with a discussion of which medications you are taking. Additional medications may be needed to protect your stomach. If you have a personal or family history of heart, liver, kidney or gastro-intestinal (GI, stomach) disease, please be additionally certain to discuss this with us, your family doctor and/or other specialists.

Generally, Tylenol™ can be taken safely with these medications. Consumption of alcohol with the use of these medications raises the risks of stomach problems, ulcers, and other dangerous side effects.

**Ultram™ (Tramadol)**

Also comes as Ultracet™ (which includes Tylenol™, see above)

You should not take this medication if you have a history of seizures or if you take Celexa™ (citalopram), Lexapro™ (escitalopram), Luvox™ (fluvoxamine), Paxil™ (paroxetine, Pexeva™), Prozac™ (fluoxetine), Zoloft™ (sertraline), MAOI's.

**Lidoderm™ Patches**

You must completely remove the patch after 12 hours use and leave it off for 12 hours before applying a new one.

**NARCOTIC PRESCRIBING POLICY**

1. Given the nature of your injury or condition, you should only require narcotic pain medication for a certain amount of time, if at all. Every effort on our part will be used to switch you over to nonnarcotic pain medication as soon as your pain level permits. Our office, your pharmacy and your insurance company will closely monitor your prescription refills for excessive, abusive or long-term use. If necessary, you will be referred to a pain management specialist. Failure to seek care with the pain management specialist when referred could result in possible termination of your care.

2. You must use only one pharmacy for these prescriptions. If you feel that you have good reason and must change pharmacies, you must notify your doctor in advance. All pharmacies involved will be notified of the change. If, at any time, it is discovered that you are using more than one pharmacy for the same medication, you will be referred to a pain management specialist. In some situations, possible termination of care may result.

3. It is your responsibility to call our office for refill requests in a timely manner. Your doctor is not in the office everyday. 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.

4. We ask patients to inform us of their present medications. Please tell us of any new medications that you have received from other physicians at each appointment. It is your responsibility to make sure that any new prescriptions that you receive from other physicians are not similar or the same medications, perhaps by different or generic names, for other painful conditions. We must be kept aware of all medication changes by other physicians, as this can be a potentially dangerous situation. If at any time it is discovered that you are using several different doctors to obtain narcotics, you will immediately be referred to a pain management specialist and immediate termination of care may result.

5. We do not keep pain medications in our office.

6. EARLY REILLS 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

These are highly controlled medications. It is your responsibility to take them only as prescribed and according to directions. It is your responsibility to store them legally, safely and out of reach of others. Your irresponsibility or failure to do so will result in an immediate change to non-narcotic medications, possible referral to a pain management specialist, and possible termination of care.

I HAVE READ AND UNDERSTAND THE ABOVE MEDICATION POLICY.

PATIENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



John M. Keggi, M.D.  
Robert E. Kennon, M.D.  
Lee E. Rubin, M.D.

### HIPAA RELEASE FORM

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date