# VERGHESE ORTHOPEDICS

## Patient Registration Form

Patient: _____( )Male ( ) Female

Last Middle Initial First

Birth Date: _____ Age: _____ ( ) Single ( ) Married ( ) Widowed

Home Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____Portal Access? ( ) Yes ( ) No

Employer: _____ Occupation: _____

Spouse's Name: _____ Date of Birth: _____

Insurance Policy Holder: _____

Relationship to Patient: _____Policy Holder's Date of Birth _____

****WE MUST HAVE A COPY OF YOUR INSURANCE CARD AND PHOTO ID IN YOUR CHART****

I authorize:

1. The physician and staff to provide medical treatment, testing and care deemed necessary.

2. The release of medical information necessary to process medical claims.

3. The payment of medical benefits to this office.

_____ _____

Patient Name (printed) Legal Guardian Name (print)

_____ _____

Patient/Legal Guardian Signature Date

# VERGHESE ORTHOPEDICS

## CONSENT

**Consent to and Conditions for Treatment:**

The terms and conditions that apply to the care, treatment and other services provided by George B. Verghese, MD are set forth below. Please read these terms and conditions very carefully.

**Consent to Treatment:**

I, the individual whose signature appears below, wither on my own behalf or on behalf of the person identified below (whom I am legally authorized to represent), hereby authorize and voluntarily consent to all care, treatment and other related services (including, for example, diagnostic procedures, tests, radiology, anesthesia, x-ray interpretation, emergency care, the administration of fluids and medications, and other nursing, medical and surgical treatment and care) that may be ordered, requested, directed or provided by Dr. Verghese.

I understand that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made, or can be made, regarding my care, treatment or other related services that may be provided by Dr. Verghese.

**Financial Agreement:**

**I understand that if I do not appear for an appointment or do not cancel my appointment within 24 hours, a fee of $25.00 will be applied to my account.**

I agree to pay for all care, treatment and other related services provided to me (or the person identified below) by Dr. Verghese. No assignment of benefits or acceptance of partial reimbursement shall be deemed a waiver of Dr. Verghese's right to require full payment of all amounts associated with such care, treatment or other related services. I acknowledge that I will be charged, and agree that I will pay interest (at a rate no higher that permitted by law) on any overdue amounts until they are paid in full. If my account is referred for collection, I agree to pay for all costs of collection, including any reasonable attorneys' fees and court costs. I understand and agree that any over-payments collected by Dr. Verghese with regard to any particular care, treatment or services provided to me may be applied to any outstanding amounts then due and payable to Dr. Verghese for which I am legally responsible.

**Assignment of Benefits:**

I irrevocably assign and transfer to Dr. Verghese all health, medical or other related benefits payable on my behalf (or on behalf of the person identified below) under any contract of insurance or from any other source, governmental or private. I authorize Dr. Verghese to directly apply for, and to directly receive payment of , any such benefits. I acknowledge and understand that Dr. Verghese is not responsible for care, treatment or other services provided to me, and I agree that I am solely responsible for all charges incurred with regard to such care, treatment and services, regardless of the existence or extent of insurance coverage (including any deductibles or co-payment amounts associated with any such insurance coverage).

Use and Disclosure of Health Information:

I authorize Dr. Verghese and each applicable health care provider to disclose health-related information and medical records about me (or as applicable, the person identified below) amongst themselves for use in providing care, treatment or other related services. If I am transferring to another health care facility, or to another physician, I authorize Dr. Verghese, or the applicable transferring facility or physician, to disclose and the receiving facility or physician, or Dr. Verghese, to receive and use, copies of health related information and medical records about me for the purpose of providing care and treatment.

I authorize Dr. Verghese and each applicable health care provider to disclose health related information and medical records bout me to any person or entity (including, for example, my insurance company, employer or a private review organization) to the extent necessary for the submission processing and payment of any claim for the benefits related to the records related to the diagnosis and treatment of medical illness or drug and alcohol abuse and the results of blood tests performed to determine the presence of infectious diseases including, for example human immunodeficiency virus (HIV). I consent to all such disclosures and waive any claims that may be available under federal or state law that such disclosures represent a breach of obligations of confidentiality.

I authorize the disclosure to governmental agencies or entities of such information about me as they are authorized by law to collect or receive.

If, in connection with my care or treatment, an employee of Dr. Verghese is exposed to my blood or bodily fluids, I authorize and consent to a sample of my blood being drawn and tested for infectious diseases of any nature or description.

Acceptance and Signature:

X _____ Date: _____

I represent that I, either as the person identified below or such person's legal representative, have read and understand, and am duly authorized to accept and execute these terms and conditions. Any questions that I have had, have been satisfactorily answered. I hereby accept and agree to be bound by all of the above terms and conditions and I agree that a copy of this document may be used in enforcing any rights hereunder.

_____

Patient Name (printed) Patient DOB

_____

Patient Signature (or responsible individual) Date

_____

Relationship to Patient Witness

# PERMISSIONS AND CONTACT INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosers of their personal health information (PHI). This individual is also provided the right to request confidential communications or that a communication for PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner regarding my PHI:**

**(check all that apply)**

____ Home Phone: __(___)_____

_____ Leave message with detailed information

_____ Leave message with call back number only

____ Work Phone: __(___)_____

_____ Leave message with detailed information

_____ Leave message with call back number

_____ Cell Phone: __(___)_____

_____ Leave message with detailed information

_____Leave message with call back number

_____ Written Communication:

_____Home Mailing Address: _____

_____ Work Mailing Address: _____

_____ Other: _____

EMERGENCY CONTACT INFORMATION:

Name: _____Phone: _____

Name: _____Phone: _____

_____

Patient Signature Date

# PATIENT MEDICAL HISTORY

Patient's Name: _____ DOB: _____

Reason for today's visit: _____

Date of Injury:_____ If not injury, pain for how long? _____

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy & location: _____

Height: _____ Weight: _____

**Allergies:** **Yes____** **No____**

Name: _____Reaction:_____

Name:_____Reaction:_____

Name:_____Reaction:_____

Name:_____Reaction:_____

**Current Medications:**

Name: _____Dose: ____Frequency: _____ Reason: _____

Name:_____Dose:_____Frequency:_____Reason:_____

Name: _____Dose:_____Frequency:_____Reason:_____

Name:_____Dose:_____Frequency:_____Reason:_____

Name:_____Dose:_____Frequency:_____Reason:_____

**Please list all major FAMILY health problems (i.e.; diabetes, high blood pressure, cancer, etc):**

Problem: _____Family Member: _____

Problem: _____Family Member: _____

Problem: _____Family Member:_____

Problem: _____Family Member: _____

Problem: _____Family Member: _____

**(Father, Mother, Brother, Sister, Maternal and Paternal Grandparents , Aunts and Uncles)**

**Social History:**

Are you a current smoker? Yes No Previous smoker? Yes No

How much alcohol per week? None___ Occasional___ Moderate ___ Heavy____

Do you live alone? Yes No Stairs? Yes No How many? ____

What type of work do you do? _____

**Patient's Past Medical History (Please check all that apply)**

_____ AIDS/HIV

_____ Anxiety/Depression

_____ Arthritis/Osteoarthritis

_____ Asthma

_____ Bleeding Disorder

_____ Blood Clot-DVT

_____ COPD

_____ Cancer- Type: _____

_____ Coronary Artery Disease

_____ Diabetes- Type:_____

_____ Difficulty Swallowing

_____ Heart Attack- MI

_____ Heart Problems

_____ Hypertension- HTN/ High Blood Pressure

_____ Pacemaker

_____ Peripheral Vascular Disease

_____ Rheumatoid Arthritis

_____ Seizures/Epilepsy

_____ Stroke

_____ Thyroid Problems

_____ Tuberculosis

_____ Skin Problem-Type:_____

_____ UTI- When: _____

_____ Bronchitis- When: _____

_____ Knee Pain- Side: _____

_____ Hip Pain- Side: _____

_____ Shoulder Pain- Side: _____

**Patient's Past Surgeries:**

Procedure: _____Date:_____

Procedure: _____Date: _____

Procedure: _____Date: _____

Procedure: _____Date: _____

Procedure: _____Date: _____

Have you or a family member had complications/reactions from anesthesia? ___Yes ____No

If Yes, please explain: _____