

# Desert Orthopedic Hand Center

## REGISTRATION FORM

### Section I: Patient Information

Date \_\_\_\_\_

Name: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

May we leave a message on your home phone? \_\_\_\_\_ Work phone? \_\_\_\_\_ Cell Phone? \_\_\_\_\_

Patient Sex: M / F Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Widowed  Separated  Divorced

If Student, Name of School: \_\_\_\_\_ City/State: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

If injury filed under Worker's Compensation, what was your Date of Injury? \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone#: \_\_\_\_\_

### Section II Primary Insurance Information

**\*It is our policy to obtain a copy of both your insurance card(s) and a valid picture ID\***

Insurance Co. Name: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Policyholder: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Policy # / ID #: \_\_\_\_\_ Group # / Claim #: \_\_\_\_\_

### Section III Secondary Insurance Information

Insurance Co. Name: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Policyholder: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Policy # / ID #: \_\_\_\_\_ Group # / Claim #: \_\_\_\_\_

**Payment Authorization:** I hereby authorize payment directly to Kraig M. Burgess, D.O., P.C., 15830 N. 35<sup>th</sup> Ave., Phoenix, AZ 85053, for the medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by insurance. I acknowledge that if I have health insurance coverage, my health insurance may include a provision for billing other sources of payment for my total bill.

**General Information:** Tape or video recordings are strictly prohibited unless advance written permission is received by the physician. This office will maintain your medical record for six years from the date of your last visit.

**Patient/Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DESERT ORTHOPEDIC HAND CENTER**

**INITIAL OUTPATIENT VISIT AND CONSULTATION**

Please provide the following medical information to the best of your ability:

<b>Patient Name: PLEASE PRINT</b>		<b>Date</b>	
Name of Primary Physician			
Are You	<input type="checkbox"/> Right Handed	<input type="checkbox"/> Left Handed	Age _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F
What problem are you here for today?		When did your problem first begin?	
How much pain do you have? (Circle) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (Worst)			
How did it occur?		Where did it occur?	
Was your injury the result of an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please check appropriate box <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			
Explain:			
What makes it <b>Worse</b> ?		What makes it <b>Better</b> ?	
Are there other symptoms? <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Swelling <input type="checkbox"/> Loss of joint motion <input type="checkbox"/> Joint Locking <input type="checkbox"/> Joint popping out of place <input type="checkbox"/> Pain radiating to:			
Treatments you already tried:			
If you've had the following <b>Tests</b> , please give <b>date</b> and <b>location</b> :			
<b>X-Rays:</b>		<b>MRI:</b>	<b>Nerve Study:</b>
<b>Review of Systems:</b> 1.)Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:			
		<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
General	chills	<input type="checkbox"/> <input type="checkbox"/>	weight loss <input type="checkbox"/> <input type="checkbox"/>
	fever	<input type="checkbox"/> <input type="checkbox"/>	weight gain <input type="checkbox"/> <input type="checkbox"/>
EYES	eye pain/pressure	<input type="checkbox"/> <input type="checkbox"/>	recent vision changes <input type="checkbox"/> <input type="checkbox"/>
ENT	hearing loss	<input type="checkbox"/> <input type="checkbox"/>	snoring <input type="checkbox"/> <input type="checkbox"/>
CARDIAC	chest pain	<input type="checkbox"/> <input type="checkbox"/>	palpitations <input type="checkbox"/> <input type="checkbox"/>
	ankle swelling (not injured)	<input type="checkbox"/> <input type="checkbox"/>	shortness of breath <input type="checkbox"/> <input type="checkbox"/>
RESPIRATORY	productive cough	<input type="checkbox"/> <input type="checkbox"/>	coughing blood <input type="checkbox"/> <input type="checkbox"/>
	wheezing	<input type="checkbox"/> <input type="checkbox"/>	
GI	difficulty swallowing	<input type="checkbox"/> <input type="checkbox"/>	heartburn/indigestion <input type="checkbox"/> <input type="checkbox"/>
	stomach/abdominal pain	<input type="checkbox"/> <input type="checkbox"/>	nausea/vomiting <input type="checkbox"/> <input type="checkbox"/>
	recent change in bowel habits	<input type="checkbox"/> <input type="checkbox"/>	blood in stool <input type="checkbox"/> <input type="checkbox"/>
GU	frequent urination	<input type="checkbox"/> <input type="checkbox"/>	painful urination <input type="checkbox"/> <input type="checkbox"/>
	blood in urine	<input type="checkbox"/> <input type="checkbox"/>	urinary incontinence <input type="checkbox"/> <input type="checkbox"/>
MSK	generalized joint pain	<input type="checkbox"/> <input type="checkbox"/>	generalized muscle pain <input type="checkbox"/> <input type="checkbox"/>
SKIN	rash	<input type="checkbox"/> <input type="checkbox"/>	hives <input type="checkbox"/> <input type="checkbox"/>
NEURO	headache	<input type="checkbox"/> <input type="checkbox"/>	dizziness <input type="checkbox"/> <input type="checkbox"/>
	passing out	<input type="checkbox"/> <input type="checkbox"/>	numbness, tingling <input type="checkbox"/> <input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/> <input type="checkbox"/>	claustrophobia <input type="checkbox"/> <input type="checkbox"/>
HEME/LYM	night sweats	<input type="checkbox"/> <input type="checkbox"/>	bleeding problems <input type="checkbox"/> <input type="checkbox"/>
IMMUNOLOGY	seasonal allergies	<input type="checkbox"/> <input type="checkbox"/>	
<b>Past Medical History:</b>			
1.) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain			
<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
<input type="checkbox"/> <input type="checkbox"/> Abnormal heart beat	<input type="checkbox"/> <input type="checkbox"/> Diabetes (on insulin)	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	<input type="checkbox"/> <input type="checkbox"/> <b>Sleep Apnea</b>
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Diabetes (taking pills)	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Use CPAP
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Lung Problems	<input type="checkbox"/> <input type="checkbox"/> Thyroid problems
<input type="checkbox"/> <input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Paralysis	<input type="checkbox"/> <input type="checkbox"/> T.B.
<input type="checkbox"/> <input type="checkbox"/> Blood clots/DVT	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Pregnant now	<input type="checkbox"/> <input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> <input type="checkbox"/> Bone/Joint Infection	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> <input type="checkbox"/> Psoriasis	<input type="checkbox"/> <input type="checkbox"/> Valley Fever
<input type="checkbox"/> <input type="checkbox"/> Cancer of _____	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/> Other Med. Problems
<input type="checkbox"/> <input type="checkbox"/> <b>Cardiac Stent</b>	<input type="checkbox"/> <input type="checkbox"/> HIV	<input type="checkbox"/> <input type="checkbox"/> Sinus Infection	_____

**INITIAL OUTPATIENT VISIT AND CONSULTATION (CONT.)**

<b>Patient Name:</b> _____		<b>Date:</b> _____				
<b>Allergies:</b> <input type="checkbox"/> None		<u>Yes</u>	<u>No</u>	<b>Other Allergies</b>	<u>Yes</u>	<u>No</u>
1.	Reaction Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Shell Fish	<input type="checkbox"/>	<input type="checkbox"/> Latex
2.	Reaction Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Eggs	<input type="checkbox"/>	<input type="checkbox"/> Tape
3.	Reaction Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/> Contrast Dye
4.	Reaction Type _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Please List all your previous surgeries including dates (Month/Year)

A.	D.
B.	E.
C.	F.

**Please list any current medications:**

(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal suppliments, OTC nasal sprays/cold/sinus/allergy meds):

A.	E.	I.
B.	F.	J.
C.	G.	K.
D.	H.	L.

**Family History:**

Please check the "Yes" or "No" box to indicate whether any close relatives in the family have any of the following illnesses. If yes, please indicate which relative(s) have the problem.

	<u>Yes</u>	<u>No</u>	<b>Please list details below:</b>
Hypertension _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems/murmurs _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Social History:**

Yes No

Do you smoke? List how much   Pks/Day? \_\_\_\_\_ How many years? \_\_\_\_\_

If no, did you smoke previously?   Pks/Day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol?   Drinks/Day? \_\_\_\_\_ Week \_\_\_\_\_ Month \_\_\_\_\_

If female, are you pregnant?   Expected delivery date: \_\_\_\_\_

Have you used drugs?   If Yes, please check which one.  Marijuana  Methamphetamine  Cocaine

**Current Work Status**  Full Duty  Light Duty  Off Work  Retired

Job Title \_\_\_\_\_ Employer \_\_\_\_\_

Describe your job \_\_\_\_\_

What sports do you play? \_\_\_\_\_

Last Tetanus Shot \_\_\_\_\_ Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_

**Patient Signature/Legal Guardian**

**Date**

**Physician Signature**

\_\_\_\_\_