Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ________________________ (First) ____________ (MI) _____ Previous Name ______________________

Address Line 1 ____

City, State ________________________________ ZIP___________ Pharmacy______________Pharmacy Phone_______________

Home Phone ______________________ Cell No. _____________________ Work Phone _________________Ext. ___________

Primary Care Provider (PCP) _________________________________ Referring Provider ______________________________

Rendering Provider Name (this practice) ________________________________ E-Mail Address:_________________________

Date of Birth MM _______/DD _________/YYYY _____________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ___________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-______-________ Employer Name ____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ______________________________________ First Name ______________________________

Phone Number ____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____ ☐ Guardian

Address Line 1 ____

City, State ________________________________ ZIP________________

Home Phone ______________________________ Work Phone ____________________________ Ext. __________________

Referring Provider Name ____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ___________________________ (First) ___________________________ (MI) ___________

Guarantor Account Number ____________________________ Date of Birth MM _________/DD _________/YYYY ____________

Social Security Number _______-_____-________ Telephone ______________________

E -Mail Address ______________________________________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____

City, State ________________________________ ZIP ___________________

Employer____ Employer Phone Number______________________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (______)_________________

Name of Insured____ Patient Relationship to Insured______________________

Subscriber ID (Policy Number)__________________ Group ID_________________ Copay Amount____________________

Effective Date____________________ Termination Date_______________ Date of Birth MM _______/DD _______/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (______)_________________

Name of Insured____ Patient Relationship to Insured______________________

Subscriber ID (Policy Number)__________________ Group ID_________________ Copay Amount____________________

Effective Date_______________________ Termination Date________________Date of Birth MM _______/DD _______/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***_________________

HCA VA SPORTS MEDICINE
Dr. Douglas N. Cutter
Patient Health History Form

Name: ________________________________ Age____ Referral Source___________________

Reason for today's visit: ____

____

____Onset Date: _______________________________

List any x-rays, MRI's, or other diagnostic studies you've had that are <u>related</u> to today's visit:

____

PAST MEDICAL HISTORY: Have you had any of the following?
(Circle "Y" = Yes, "N" = No "F" = Family)

Arthritis	Y N F	High blood pressure	Y N F	Peptic Ulcer/GI Problem	Y N F
Asthma	Y N F	Heart disease	Y N F	Sprain /Strain	Y N F
Bleeding disorder	Y N F	Kidney disease	Y N F	Sleep disorder	Y N F
Cancer	Y N F	Neurologic disorder	Y N F	Thyroid disease	Y N F
Diabetes	Y N F	Osteoporosis	Y N F	Congenital Birth Defect	Y N F

List all operations: ____

Do you have any metal clips inside you? Yes / No If yes, location: ___________________________
Have you ever broken any bones? Yes / No If yes, location: ___________________________

List all medications and supplements you take currently: _____________________________________

____

List allergies (include food & medicine):____

Do you smoke? Yes / No If yes, how much? _______________________________
Do you drink caffeine? Yes / No If yes, how much? _______________________________
Do you drink alcoholic beverages? Yes / No If yes, how much? _______________________________

Any diet/nutritional concern: ____

____

What type of work do you do? ____

Primary sports and hobby interests: ____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors that I may have made in completion of this form.

Signature: ____ Date: ___________________________

Reviewed by: ____ Date: ___________________________