MONOCACY HEALTH PARTNERS
ORTHOPAEDIC SPECIALISTS

We appreciate the value of your time. Here are some tips to help us provide comprehensive care in an efficient manner.

- Please bring your insurance card and photo ID with you
- Please bring all forms completed to your visit.
- Payment is expected at time of service. We accept cash, check, and all major credit cards
- If you are a member of an HMO please contact your primary care physician to obtain a referral. Most offices require 48 hours' notice to issue a referral. If the reason for your visit is Auto or Workers comp related, please make sure you are bringing in all your insurance/claim information.
- If you are a new patient to our practice, please have appropriate records forwarded to our office prior to your appointment. This includes any recent office notes, labs or imaging. Your doctor's office will either mail or fax them to our office, but you must request them. Please make sure have has any requested x-rays completed.
- If there are any additional radiology testing ordered for this office visit, please have them done prior to your appointment.
- If you happen to arrive 15 minutes or more past your scheduled ***Check in time*** you may be asked to reschedule.

We are working hard to ensure your time with us is as pleasant as possible. We are committed to your care and value any feedback you may have for us. Thank you and we look forward to seeing you!

Respectfully,

Your providers and staff at Monocacy Health Partners Orthopaedic Specialists of Frederick

MONOCACY HEALTH PARTNERS
ORTHOPAEDIC SPECIALISTS

PATIENT REGISTRATION FORM

PATIENT

NAME (First, Middle, Last) | DATE OF BIRTH | BIRTH SEX ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

STREET ADDRESS OR MAILING ADDRESS (PO BOX) | CELL PHONE NUMBER | PRIMARY PHONE NUMBER

CITY STATE ZIP CODE | E-MAIL (Required for Patient Portal) | WORK PHONE NUMBER

EMPLOYER

EMPLOYMENT STATUS
☐ Full Time ☐ Part Time ☐ Self-Employed
☐ Unemployed ☐ Retired ☐ Active Duty

STUDENT STATUS
☐ Full Time ☐ Part Time ☐ Not Student

PRIMARY CARE PROVIDER

PRIMARY LANGUAGE | SOCIAL SECURITY #

MARITAL STATUS
☐ Single ☐ Married ☐ Separated
☐ Annulled ☐ Widowed ☐ Divorced
☐ Domestic Partner ☐ Interlocutory
☐ Life Partner ☐ Polygamous ☐ Unknown

PREFERRED CONTACT METHOD
(Check all that apply)
☐ Home Address(letters)
☐ Home Phone ☐ Cell Phone

RACE
☐ American Indian/Alaskan Native ☐ White/Caucasian ☐ Black
☐ Multiracial ☐ Asian/Pacific Islander ☐ Refused/undetermined

ETHNICITY
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Refused or Undetermined

CURRENT GENDER
☐ Female ☐ Male ☐ Undifferentiated

PREFERRED PRONOUN
☐ Choose not to disclose
☐ Decline to Answer ☐ She, Her, Hers
☐ He, Him, His ☐ Ze, Hir
☐ They, Them, Theirs ☐ Other

SEXUAL ORIENTATION
☐ Choose not to disclose
☐ Straight or Heterosexual
☐ Bisexual
☐ Don't Know
☐ Lesbian, gay or homosexual
☐ Something else, please describe

GENDER IDENTITY
☐ Choose not to disclose
☐ Additional gender category or other, please specify
☐ Female
☐ Female-to-Male(FTM)/Transgender Male/Trans Man
☐ Genderqueer, neither exclusively Male nor Female
☐ Male
☐ Male-to-Female(MTF)/Transgender Female/Trans Woman

RESPONSIBLE PARTY

NAME (First, Middle, Last) | DATE OF BIRTH | SEX ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

ADDRESS | TELEPHONE – HOME | TELEPHONE - WORK

RELATIONSHIP TO PATIENT
☐ Parent ☐ Guardian ☐ Other

EMPLOYER

PRIMARY INSURANCE CARRIER

INSURANCE CARRIER NAME-

INSURANCE ID# ***See card*** GROUP # ***See card***

SUBSCRIBER (POLICY HOLDER)

NAME _____ Birthdate_____

ADDRESS _____ Phone_____

PATIENT-SUBSCRIBER RELATIONSHIP
☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY INSURANCE CARRIER

INSURANCE CARRIER NAME-

INSURANCE ID # ***See card*** GROUP # ***See card***

SUBSCRIBER (POLICY HOLDER)

NAME _____ Birthdate_____

ADDRESS _____ Phone_____

PATIENT-SUBSCRIBER RELATIONSHIP
☐ Self ☐ Spouse ☐ Dependent ☐ Other

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

NAME | DAYTIME TELEPHONE | EVENING TELEPHONE

If you are here for an injury, is it: ☐ Work Related ☐ Auto Related ☐ Neither

ALL PAYMENT DUE AT TIME OF SERVICE

I authorize payment of insurance benefits directly to Monocacy Health Partners. I will be responsible for fees and charges according to Monocacy Health Partners and my health plan. If I do not provide a VALID insurance card at each visit, I will be held responsible for services. I understand that I may be contacted by Monocacy Health Partners and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages, and/or an automatic dialing device ("auto dialer"), by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

.

Patient Signature: _____ Date: _____

Or

Patient Representative_____ Relationship to Patient: _____

MONOCACY HEALTH PARTNERS
ORTHOPAEDIC SPECIALISTS

Health Insurance Portability and Accountability Act (HIPAA) Form

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Monocacy Health Partners, have been offered a copy of the Notice of Privacy Practice which describes my privacy rights in accordance to federal and state requirements.

_____ _____
Signature of Patient or Authorized Representative Date

Communication Consent

"I understand that I may be contacted by Frederick Regional Health System/Monocacy Health Partners and or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and /or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services. You may also contact me by e-mail using any e-mail address I have provided to you.

☐ Yes, you may call or text my cell phone at: _____. This communication is to confirm office appointments or leave a message regarding my care.

☐ ***No***, please ***do not*** contact me by the following means: _____

I authorize my provider and the appropriate staff to share medical/billing information about my care/account to the following individuals as indicated below:

Name(s)	Relationship(s)	Phone #(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

It is the patient's responsibility to notify Monocacy Health Partners of any changes to this form.

_____ _____
Print Patient's Name Home/Cell Phone Number (Please circle)

_____
Patient's Date of Birth

_____ _____
Patient or Legally Responsible Person's Signature Date Witness Date

Rev. 6/1/18

Office Use Only

Entered by: _____ Date: _____

MONOCACY HEALTH PARTNERS
ORTHOPAEDIC SPECIALISTS

PATIENT HEALTH HISTORY

Today's Date: _____

Patient's Last Name: _____ First: _____ MI: _____

Primary Care Physician (First & Last Name): _____

Location: _____

Employer: _____

Occupation: _____

REASON FOR VISIT: _____ **Date of Illness/Injury:** _____

FOR PATIENTS 65 YEARS OF AGE AND OLDER

Did you fall in the past year? ☐Yes ☐No How many times?_____ Did the fall(s) result in an injury? ☐Yes ☐No

Do you use a walking aid or has one been recommended? ☐Yes ☐No ☐N/A Details: _____

REVIEW OF SYSTEMS:
Are You **CURRENTLY** experiencing any of the following?

CONSTITUTIONAL ☐Normal

No	Yes	
☐	☐	Chills
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Malaise
☐	☐	Night sweats
☐	☐	Weakness
☐	☐	Weight gain
☐	☐	Weight loss

HEENT ☐Normal

No	Yes	
☐	☐	Blurred vision
☐	☐	Double vision
☐	☐	Dysphagia
☐	☐	Ear drainage
☐	☐	Facial pain
☐	☐	Headache
☐	☐	Hearing loss
☐	☐	Hoarseness
☐	☐	Nasal congestion
☐	☐	Ringing in ears
☐	☐	Vertigo
☐	☐	Vision loss

RESPIRATORY ☐Normal

No	Yes	
☐	☐	Chest pain(*respiratory)*
☐	☐	Cough
☐	☐	Dyspnea (Shortness of Breath
☐	☐	Recent infections
☐	☐	Known TB exposure
☐	☐	Wheezing

CARDIOVASCULAR ☐Normal

No	Yes	
☐	☐	Chest pain
☐	☐	Cyanosis
☐	☐	Heart murmur
☐	☐	Leg swelling
☐	☐	Syncope
☐	☐	Irregular heartbeat/ palpitations
☐	☐	Thrombophlebitis

GASTROINTESTINAL ☐Normal

No	Yes	
☐	☐	Abdominal pain
☐	☐	Constipation
☐	☐	Black tarry stools
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Jaundice
☐	☐	Loss of appetite
☐	☐	Nausea
☐	☐	Vomiting

GENITOURINARY ☐Normal

No	Yes	
☐	☐	Dysuria
☐	☐	Frequent Urination
☐	☐	Hematuria
☐	☐	Urge incontinence
☐	☐	Urinary incontinence

METABOLIC/ ENDOCRINE ☐Normal

No	Yes	
☐	☐	Cold intolerant
☐	☐	Hair loss
☐	☐	Heat intolerant

NEUROLOGICAL ☐Normal

No	Yes	
☐	☐	Difficulty walking
☐	☐	Dizziness
☐	☐	Poor coordination
☐	☐	Memory loss
☐	☐	Muscle weakness
☐	☐	Paresthesia
☐	☐	Seizures
☐	☐	Tremors

PSYCHIATRIC

No	Yes	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Insomnia

INTEGUMENTARY ☐Normal

No	Yes	
☐	☐	Contact allergy
☐	☐	Itchy skin
☐	☐	Rash
☐	☐	Skin infections
☐	☐	Skin lesion

MUSCULOSKELETAL
☐ Negative, except as noted in HPI and chief complaint

Hematologic ☐Normal

No	Yes	
☐	☐	Bleeding
☐	☐	Bruising
☐	☐	Pulmonary embolus
☐	☐	DVT

IMMUNOLOGICAL ☐Normal

No	Yes	
☐	☐	Asthma
☐	☐	Bee sting allergies
☐	☐	Contact dermatitis
☐	☐	Environmental allergies
☐	☐	Food allergies
☐	☐	Seasonal allergies

MONOCACY HEALTH PARTNERS
ORTHOPAEDIC SPECIALISTS

PAST MEDICAL HISTORY – Check all conditions you have now or have had in the past.

CANCER
☐ Type: _____

CARDIOVASCULAR (heart & blood vessels)
☐ Angina (chest pain)
☐ Arrhythmia/irregular heartbeat
☐ Blood clot/DVT (deep vein thrombosis)
Date Occurred: _____
☐ Heart attack/MI
☐ Heart disease/Coronary artery disease
☐ High cholesterol/Hyperlipidemia
☐ MVP (mitral valve prolapse)
☐ Pacemaker: year_____
☐ Varicose veins/Peripheral vascular disease
☐ Hypertension/High blood pressure
☐ Stent-Date Occurred: _____
☐ AICD (Automatic Implantable Cardioverter Defibrillator)

BONES JOINTS & MUSCLES
☐ Arthritis
☐ Degenerative joint disease
☐ Fibromyalgia
☐ Gout
☐ Osteoporosis
☐ coliosis

PSYCHIATRIC DISORDER (mental health)
☐ Anxiety
☐ Bipolar Disorder
☐ Depression
☐ Drug/Alcohol abuse
☐ Suicidal thoughts

HEENT (head, eyes, ears, nose & throat)
☐ Blind
☐ Deaf
☐ Hearing loss

PULMONARY/RESPIRATORY
☐ Asthma
☐ Emphysema
☐ COPD (chronic obstructive pulmonary disease)
☐ PE (pulmonary embolism/blood clot in lung)
Date Occurred: _____
☐ Pneumonia
☐ Shortness of Breath
☐ Sleep Apnea
☐ Currently uses a C-PAP machine
☐ TB (tuberculosis)

GENITOURINARY (kidneys & urinary tract)
☐ Renal failure
☐ Renal insufficiency
☐ UTI (urinary tract infection)
☐ Currently pregnant

NEUROLOGIC DISORDER (brain & nervous system)
☐ Alzheimer's disease
☐ Dementia
☐ MS (Multiple Sclerosis)
☐ **P**arkinson's disease
☐ Seizure disorder
☐ Stroke/CVA/TIA
Date Occurred: _____
☐ Myasthenia gravis
☐ Muscular dystrophy
☐ Migraines

HEMATOLOGIC (blood & lymph node)
☐ Anemia
☐ Edema
☐ Lupus
☐ Hemophilia
☐ Sickle cell disease
☐ Clotting disorders

GASTROINTESTINAL (stomach & digestive)
☐ Colon polyps
☐ Gastric ulcer
☐ GERD
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Hepatitis – type unknown
☐ Hernia
☐ Irritable bowel
☐ Stomach ulcer
☐ Liver disease/Cirrhosis
☐ Reflux

ENDOCRINE (hormones & metabolic)
☐ Diabetes – Type I
☐ Diabetes – Type II
☐ Diabetes – Type unknown
☐ Thyroid dysfunction
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Hemoglobin A1C_____

IMMUNE/AUTOIMMUNE & INFECTIOUS PROBLEMS
☐ AIDS
☐ HIV positive
☐ Rheumatoid arthritis
☐ MRSA (Methicillin Resistant Staph Aureus)
☐ Autoimmune disorder

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

_____

PAST SURGICAL HISTORY – Check all that apply and indicate which side R/L as appropriate.

☐ ACL surgery: year _____R/L
☐ Aneurysm: year _____
☐ Angioplasty: year _____
☐ Angio w/stent: year _____
☐ Appendectomy: year _____
☐ Arthroscopy ankle: year _____R/L
☐ Arthroscopy elbow: year _____R/L
☐ Arthroscopy hip: year _____R/L
☐ Arthroscopy knee: year _____R/L
☐ Arthroscopy wrist: year _____R/L
☐ Arthroscopy shoulder: year _____R/L
☐ Back surgery: year _____
☐ Cardiac/Heart surgery: year _____
☐ Carpal tunnel release: year _____R/L
☐ Cataract extraction: year _____R/L
☐ Colectomy: year _____
☐ Colonoscopy: year _____
☐ Colostomy: year _____
☐ Fracture: year _____
☐ Gallbladder: year _____
☐ Gastric bypass: year _____
☐ Hernia repair: year _____
☐ Hip replacement: year _____R/L
☐ Hysterectomy: year _____
☐ Knee replacement: year _____R/L
☐ Laminectomy: year _____
☐ Mastectomy: year _____R/L
☐ Meniscus surgery: year _____R/L
☐ Pacemaker: year _____
☐ Prostate: year _____
☐ Rotator cuff repair: year _____R/L
☐ Small bowel resection: year _____
☐ Thyroidectomy: year _____
☐ Transplant: year _____

☐ **OTHER SURGERIES NOT LISTED ABOVE**: _____

☐ **PROBLEMS WITH PAST ANESTHESIA (IF YES, PLEASE LIST)**: _____

☐ **CURRENTLY BEING TREATED WITH**: ☐ Dialysis ☐ Chemotherapy ☐ Radiation ☐ Oxygen (Day/Night)_____# of liters

MONOCACY HEALTH PARTNERS
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FAMILY HISTORY – Check the boxes below if any **blood** relative has been diagnosed with any of the following:

	Relationship		Relationship
☐ Anesthesia problems	_____	☐ Osteoporosis	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding/clotting problems	_____	☐ Family history unknown	
☐ Cancer: type: _____	_____	☐ No significant family history	

SOCIAL HISTORY

HAND DOMINANCE

☐ Right
☐ Left
☐ Ambidextrous

DO YOU DRINK ALCOHOL?

☐ Yes
☐ No
What kind & how much?
_____
_____

DO YOU USE TOBACCO?

☐ Yes
Type of tobacco:_____
☐ No
☐ Former
Type of tobacco: _____
Age quit: _____

CURRENT/FORMER ILLICIT DRUG USE

☐ None
☐ Current
What kind? _____
☐ Former
What kind? _____
Date quit: _____

MEDICATIONS-Please list any medication(s) you are currently taking, include prescribed medications, vitamins, supplements and over-the-counter medications

MEDICATION	DOSAGE/DIRECTIONS	PROBLEM BEING TREATED	PRESCRIBING DOCTOR

☐ MEDICATION LIST COPIED, SEE ATTACHED MEDICATION LIST
Pharmacy Preference (include location): _____

Are you being treated by pain management? ☐ Yes ☐ No If so, where? _____

ALLERGIES:
Are you allergic to?: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Latex ☐ Betadine ☐ Tape ☐ IVP dye

☐ Iodine/shellfish ☐ Eggs, Birds/Feathers ☐ Other ☐ **I HAVE NO KNOWN ALLERGIES**

☐ Reaction: _____

CURRENT TREATING PHYSICIANS:

Cardiologist: _____ Pulmonologist: _____ Neurologist: _____

Endocrinologist: _____ Hematologist: _____ Other: _____

_____ _____ _____
Patient/Guardian Signature Date of Birth Date