SEASIDE ORTHOPAEDIC CLINIC, Inc.
RICHARD L. YOUNG, M.D.
American Board of Orthopaedic Surgery

UPON COMPLETION OF PATIENT REGISTRATION PACKET, PLEASE BRING ALL FORMS TO YOUR APPOINTMENT. YOU MAY ALSO FAX COMPLETED FORMS TO THE OFFICE AT 910-575-9103. THANK YOU.

PATIENT INFORMATION

Patient's Name: _____ **Birthdate:** _____ **( ) F ( ) M**
LAST FIRST MI

Address: _____
STREET CITY STATE ZIPCODE

Address (OTHER- Please list Mailing Address if different than above):

_____
STREET (PO BOX) CITY STATE ZIPCODE

( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed Occupation: _____

Home Phone: _____ **Social Security No:** _____

Work Phone: _____ **Driver's License No:** _____

Cell Phone: _____ **EMAIL ADDRESS:** _____

Employer Name & Address: _____

Referring Physician: _____ **Family Physician:** _____

Pharmacy (Local): _____ **(Mail order)** _____

Responsible Party (if not the patient) and/or if the Patient is a Minor

Responsible Person: _____ **Relationship To patient:** _____ **Birthdate:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Address: _____
STREET CITY STATE ZIPCODE

Father's Name: _____ **Birthdate:** _____ **SSN:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Address (if different from patient) _____
STREET CITY STATE ZIPCODE

Mother's Name: _____ **Date of Birth:** _____ **SSN:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Address (If different from patient) _____
STREET CITY STATE ZIPCODE

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Patient's Name_____Birthdate: _____

INSURANCE INFORMATION

PRIMARY Insurance: _____ID# _____Group #_____

Patient's Relationship to Policy Holder: ( )Self ( )Spouse ( )Child ( )Other

Policy Holder's Name (if other than patient) _____

Social Security No: _____ Birthdate: _____

SECONDARY INSURANCE: _____ID# _____Group #_____

Patient's Relationship to Policy Holder: ( )Self ( )Spouse ( )Child ( )Other

Policy Holder's Name (if other than patient) _____

Social Security No: _____ Birthdate: _____

********COMPLETE THIS SECTION IF VISIT IS FOR WORKMEN'S COMPENSATION INJURY********

Date of Injury: _____Body Part Injured: _____

WC Insurance Company: _____
WC Insurance Company Address:_____
WC Insurance Company TEL #_____ FAX #: _____

CLAIM NUMBER: _____ Employer at time of injury: _____

Case Manager Name: _____Tel: _____
Fax: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____Phone: _____
Relationship to Patient _____

Signature of Patient or Person Completing this form Date

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Patient: _____Today's Date: _____

What part of your body is to be examined: _____□ LEFT □ RIGHT □ BOTH

Circle any symptoms that apply: Pain Swelling Weakness Instability Tingling/Numbness
Describe any other symptoms: _____

When did Symptoms begin? _____Rate your Pain: Scale 1 – 10 _____(Ten being the worse)

Was the problem caused by an injury? □ YES □ NO Is injury JOB RELATED? □ YES □ NO

DATE OF INJURY (if applicable) _____ DATE OF ONSET _____

Describe the accident/injury (if applicable): _____
_____

If not an injury, how did symptoms begin? □ Gradually □ Suddenly
Is the condition □ Intermittent or □ Constant

What makes the condition worse or better? (Please describe) _____
_____

Have you had a similar problem in the past? □ Yes □ No If yes, describe: _____
_____
Have you seen another Health Care Provider for this problem? □ Yes □ No
If so, please list name of provider: _____

WHAT SPECIFIC TREATMENT HAVE YOU HAD? (please check what is applicable)

□ NONE	□ Pain Medications	□ Shoe Modification
□ Brace	□ Arthritis Medications	□ Orthotics/Insoles
□ Casting	□ Crutches	□ Wooden Soled shoe
□ Cortisone Injection	□ Physical Therapy	□ Ice or Heat Therapy

□ X-rays (if so, where: _____)
□ MRI (if so, where: _____)
□ Other: _____
Do you Exercise? □ Yes □ No If so, type of exercise: _____
How far can you walk without stopping? (if applicable) _____Blocks or _____Miles

This information is Complete and Accurate to the Best of My Knowledge

Signature of the person completing the form: _____Date: _____

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Patient's Name: _____DOB: _____ Today's Date: _____

Past Medical History: (Check any illnesses you may have or have had in the past)

□ NONE □ Blood Clots □ Osteoporosis
□ Gastric Ulcer □ High Blood Pressure □ Heart Attack
□ HIV □ Diabetes □ Stroke
□ Rheumatoid Arthritis □ Osteoarthritis □ Bleeding Disorder
□ Cancer: Specify _____
□ Hepatitis: Specify _____
□ Other: _____

Past Surgical History: (Check any surgeries that you have already had)

□ NONE □ Appendectomy □ Gallbladder
□ Heart Surgery □ Hysterectomy □ Tonsillectomy
□ Total Joint Replacement: Specify _____
□ Fracture Repair: _____
□ Other: _____

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, heart medications and supplements.

□ NONE

Name	Strength	Frequency	Name	Strength	Frequency

Allergies: (Check all that apply and please list your reaction to any allergies)

□ NO KNOWN DRUG ALLERGIES □ Anesthetic □ IODINE
□ Demerol □ Aspirin □ Sulfa
□ Morphine □ Penicillin
□ Other: _____ □ Codeine

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Signature of person completing form: _____Date: _____

Patient: _____ Height: _____ Weight: _____

Social History: (Please check) □ Married □ Widowed □ Divorced □ Single

Do You Live Alone? □ Yes □ No If No, who do you live with: _____

Do you smoke? □ Yes □ No Packs/Day: _____Number of years you have smoked? _____

Do you drink alcohol? □ Yes □ No Drinks/Week: _____

Occupation: _____

Family History: Please circle all that have significance in your family's history, NOT your HX

Father has	Arthritis	Diabetes	Heart Disease	Stroke	Cancer	Deceased
Mother has	Arthritis	Diabetes	Heart Disease	Stroke	Cancer	Deceased
Siblings have	Arthritis	Diabetes	Heart Disease	Stroke	Cancer	Deceased

List family history of orthopaedic problems: _____

Other: _____

Review of Systems: Circle all symptoms that apply to you from each of the 10 Categories.

THIS

1.Constitutional	Night Sweats	Fever/Chills	None
	Unexpected Weight loss/gain	Lbs in the last year? _____	
2.Endocrine	Cold Intolerance	Excessive Thirst	None
	Heat Intolerance	Frequent Urination	
3.Respiratory	Cough	Wheezing	None
4.Cardiovascular	Chest Pain at Rest	Chest Pain with Exertion	None
	Irregular Heart Beat	Palpitations	
	Shortness of Breath		
5.Gastrointestinal	Abdominal Pain	Blood in Stool	None
	Exposure to Hepatitis	Heart Burn	
	Nausea		
6.Hematology	Easy Bruising	Prolonged Bleeding	None
	Recent Transfusion		
7.Genitourinary	Difficulty Urinating	Painful Urination	None
8.Musculoskeletal	Gout	Arthritis	None
	Joint Stiffness	Painful Joints	
9.Skin	Keloid Formation	Rash	None
	Scaly Lesions of Skin/Scalp		
10.Neurologic	Dizziness	Fainting	None
	Tingling/Numbness	Loss of use of extremity	
	Gait Abnormality		

INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature of person completing form: _____Date:_____

Seaside Orthopaedic Clinic, Inc.
Notice of Privacy Practices Acknowledgement Form
Consent to Use or Disclose Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting any Seaside Orthopaedic Clinic Supervisor. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment payment and health care operations as described in our Notice. These disclosures may be by phone, mail, fax or electronic transmission. Unless you indicate otherwise in writing (by completing the form: Request for Restrictions on Use and Disclosure of Protected Health Information), if you allow a third party other than one of the practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of your PHI to that third party. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Seaside Orthopaedic Clinic may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information (PHI) to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the information in this acknowledgement. I am the patient or am authorized to act on behalf of the patient to sign this document. By signing below, I acknowledge and agree to the above conditions.

_____ _____
Print name of patient (or authorized representative) Signature of patient (or authorized representative)

_____
Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____ whose signature appears below, authorize Seaside Orthopaedic Clinic, Inc and Its Affiliated Providers to view my external prescription history via the Rx Hub service.
I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____
Patient's Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

Daytime Telephone Number _____

I HEREBY AUTHORIZE:
Seaside Orthopaedic Clinic, Inc
1733 Seaside Road SW, Suite C
Ocean Isle Beach, NC 28469
910-575-9099 Telephone
910-575-9103 Fax

To Release Information To:

_____
Name of Person or Organization

_____ _____
Address Phone Number

_____ _____
City, State, Zip Code Fax Number

This Release Includes: (Please Check Box for Requested Records)

☐ All Records ☐ Date of Service _____

☐ Lab ☐ X-Ray Reports

☐ Other: _____

This authorization shall be valid until written notice is received. Please indicate a date after which no information can be released. If no date is given, consent will be valid for 90 days only. I further understand that I have a right to receive a copy of this authorization upon request.

_____ _____

Patient's Signature OR Date:
Parent, Guardian or Authorized Representative