*Have you been vaccinated for COVID: Y / N
*Have you ever tested positive for COVID: Y / N

ORTHOPAEDIC SURGICAL ASSOCIATES

Patient Registration Form

PATIENT INFORMATION Date:____/____/____

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____ E-Mail Address: _____

Street Address: _____Apt#: _____City: _____ State: _____Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Gender: **M / F** SS#: _____ Marital Status:Married / Single / Divorced / Widow / Separated

Are you on Disability? **Y / N** If yes, why? _____

Occupation: _____ Ethnicity: **White / African American / Hispanic / Asian / Other:** _____

Emergency Contact: _____ Relationship: _____ Telephone: _____

Primary Care Physician: _____

Is patient a resident at a long-term care facility? **Y / N** If yes, Facility Name: _____

INSURANCE INFORMATION **(Please present your insurance card for photocopying)**

PRIMARY INSURANCE: _____ ID: _____ Group: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber Place of Employment: _____ Subscriber DOB: _____

SECONDARY INSURANCE: _____ ID: _____ Group: _____

Insurance Address: _____

Subscriber Place of Employment: _____ Subscriber DOB: _____

DATE OF INJURY: _____

Reason for visit: _____ **Left / Right / Both** Hand Dominance: **Right / Left**

How long have your symptoms been present? _____

Brief description of how injury occurred: _____

_____

Is injury work related? **Y / N** Currently working / employed? **Y / N** Auto Accident? **Y / N** Lawsuit Pending? **Y / N**

If the injury is not work or auto related, please sign the following statement:

I certify that this injury is not related to work or an auto accident:

Signature: _____ **Date:** _____

MEDICAL INFORMATION:

Present Medications: **Pharmacy's Name, Address & Phone Number:** _____

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____
6. Name: _____

Allergies to Medications (Please list Medications and Reactions) :

1. _____
2. _____
3. _____
4. _____

Do you have any allergies to metals? Y / N
Height : _____ **ft.** _____**in.** **Weight:** _____ **lbs. (MANDATORY)**

REVIEW OF SYMPTOMS: (Please check all that apply)

Is your Primary Care Physician aware of the symptoms below? **Y / N**

- ❑ Fever
- ❑ Night Sweats
- ❑ Recent Weight Gain (_____ lbs.)
- ❑ Recent Weight Loss (_____lbs.)
- ❑Difficulty Hearing
- ❑ Heart or Chest Pain
- ❑ Shortness of Breath
- ❑Nausea or Vomiting
- ❑ Poor Appetite
- ❑ Frequent Diarrhea
- ❑ Black Stool
- ❑ Frequent Urination
- ❑ Rash
- ❑ Recent Loss of Consciousness
- ❑ Alcohol Abuse
- ❑ Excessive Bleeding

EXISTING / PAST MEDICAL HISTORY: (Please check all that apply)

- ❑ Anemia
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Cancer: Type: _____
- ❑ Coronary Artery Disease
- ❑Depression
- ❑ Diabetes (Insulin or Non-Insulin)
- ❑ GERD / Reflux
- ❑ Gout
- ❑ Heart Attack (MI)
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ HIV or AIDS
- ❑ Hypertension
- ❑ Kidney Disease
- ❑ Leg or Foot Ulcers
- ❑ Liver Disease
- ❑Lung Disease
- ❑ Migraines
- ❑Osteoporosis
- ❑ Pace Maker
- ❑ Peripheral Vascular Disease
- ❑ Pulmonary Embolism
- ❑ Rheumatoid Arthritis
- ❑ Seizures / Epilepsy
- ❑ Sleep Apnea
- ❑ Stroke
- ❑Thyroid Problems
- ❑Tuberculosis
- ❑Ulcers

Y / N Other Medical Problems: _____

PREVIOUS SURGERIES: (please check all that apply & include dates)

- ❑ AAA Repair_____
- ❑Abdominal Surgery_____
- ❑Cancer Surgery _____
- ❑Cardiac Catheterization_____
- ❑Chest Surgery_____
- ❑ Heart Stent Placement_____
- ❑Heart Surgery_____
- ❑Leg Amputation_____
- ❑Neck Surgery _____
- ❑Brain Surgery_____
- ❑Orthopaedic Surgery_____
- ❑Pace Maker_____
- ❑Plastic Surgery_____
- ❑Lower Back Surgery_____
- ❑Thyroid Surgery_____
- ❑Vascular Surgery_____

❑Please list specific surgeries and dates: _____

_____

_____

EXISTING FAMILY HISTORY: (Please check all that apply)

- ❑Bleeding Disorders
- ❑Cancer
- ❑Diabetes
- ❑Heart Disease
- ❑Hypertension
- ❑Malignant Hyperthermia
- ❑Osteoarthritis
- ❑Rheumatoid Arthritis

SOCIAL HISTORY:

Do you smoke? **Y / N** If yes, how many packs/day? _____ How many years? _____
E-Cigarettes: **Y / N**
Smokeless Tobacco: **Y / N** ❑Chewing Tobacco ❑ Moist Powdered Tobacco

Do you drink alcohol? **Y / N** If yes, how often? _____How many years? _____
History of Intravenous Drug Use? **Y / N**

OSA ORTHOPAEDICS

Orthopaedic Surgical Associates

Telephone: (978) 454-0706

Samuel D. Gerber, MD
F.A.C.S.
Sports Medicine
Knee and Shoulder Surgery
Arthroscopic Surgery

Eric D. Holstein, MD
General Orthopaedics
Sports Medicine
Fracture Care

Scott A. Sigman, MD
Sports Medicine
Knee and Shoulder Surgery
Arthroscopic Surgery

Steven Alter, MD
Hand and Upper Extremity Surgery
Trauma Surgery

Mark A. Lapp, MD
Spinal Surgery
Asst. Professor of Orthopaedics
Tufts University School of Medicine

W. Howard Wu, MD
Sports Medicine
Arthroscopic Surgery
Joint Reconstruction

Atul L. Bhat, MD
Interventional Physiatry
Spinal Disorders

Jeremy M. Moses, MD
Sports Medicine
Knee and Shoulder Surgery
Arthroscopic Surgery

David J. Prybyla, MD
Joint Reconstruction
Fracture Care

Christopher W. Baker, MD
Foot and Ankle Surgery
Trauma Surgery

Elisabeth Gennis, MD
Hand Surgery
Fracture Care

Matthew J. Sabatino MD
Reconstructive Spine Surgery
Scoliosis & Spine Deformity
Minimally Invasive Spine Surgery

Steven T. DiSenga, MD
Orthopaedic Surgery
Joint Reconstruction

Jessica Carey, NP-C
Roula Johnstone, NP-C
Kristen Proverb, NP-C
Jane Stott, NP-C
Allison Devine, PA-C
Stacey Murphy, FNP-C

Merrimack Valley Spine Center

Telephone: (978) 654-5050

Authorization to pay benefits to Orthopaedic Surgical Assoicates:

I hereby authorize my insurance company and/or companies to pay directly to Orthopaedic Surgical Associates any proceeds payable under the terms of my policy and/or policies is my obligation and will be paid by me. I hereby authorize Orthopaedic Surgical Associates to release any information necessary to process this claim. **Effective March 1, 2013,** for any account sent to Collections, the patient /or guarantor will be liable to any fees associated with the collection process.

Signature:_____ Date:_____

HIPAA REGULATIONS: (ON LEDGE OF CHECK IN WINDOW)

I acknowledge having received a copy of the organization's Notice of Privacy Practice.

Signature:_____ Date:_____

As an HMO member, I understand that I have an obligation to obtain a referral from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have a referral for today's appointment that I will be responsible for payment of services should they be denied by my HMO plan.

Signature: _____ Date:_____

Team Physicians - UMASS Lowell
14 Research Place, North Chelmsford, MA 01863 | Fax: (978) 970-0454

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Stacey Murphy, FNP-C

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Financial Policy

It is the patient / parent / guardian's responsibility to:

- Be familiar with the benefits of your insurance plan including co-pays, co-insurance, and deductible and referral authorization requirements.
- Bring all insurance cards to all visits.
- Provide our office with current information including address, telephone numbers, driver's license or ID and name of your employer.
- Be prepared, in accordance with your insurance contract, to pay your co-payments at the time of your visit.
- Obtain a referral, if required in order for your visit to be covered by insurance. If you do not have a referral you may be asked to sign a waiver or have your appointment re-scheduled.
- Be prepared to pay a deposit prior to the date of any procedures that are scheduled for you if you insurance has a deductible. A $300.00 deposit is required for elective surgeries. If you have met your yearly deductible the deposit may be waived. There will be an opportunity to provide payment by credit card, cash, or check. The amount charges will not exceed your deductible or the payment amount allowed by your insurance for the procedure you are having.
- Effective April 1, 2013, there will be a $50.00 fee charged to patients who fail to give 24 hour notice for cancellation or re-scheduling of an appointment.

Please be advised that a diagnosis will not be modified to fit your plan benefits.

Our office participates in most major insurance plans. We accept cash, checks, and Mastercard or Visa.

_____ _____

Signature of patient / parent / guardian Date

_____

Printed Name of Patient

Team Physicians - UMASS Lowell

14 Research Place. North Chelmsford. MA 01863 | Fax: (978) 970-0454

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Orthopaedics Surgical Associates to speak with and release any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages/Records

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments, medical treatment, care, test results or financial information

_____I authorize _____ to pick up medical records, work notes, school notes, prescriptions.

Patient Name (PLEASE PRINT) _____

Signature_____**Date**_____