

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT REGISTRATION FORM**

PATIENT INFORMATION					
Patient Name Last First Middle			<input type="checkbox"/> Mr <input type="checkbox"/> Mrs	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow	
			<input type="checkbox"/> Miss <input type="checkbox"/> Ms		
Is this your legal name? <input type="checkbox"/> YES <input type="checkbox"/> NO		If not, what is your legal name?		Birthdate / /	
				Age Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T	
Street or Mailing Address (circle one) City State Zip Code			Home Phone Number ( )		
Cell Phone Number ( )		E-Mail Address (To be used for appointment reminders)		Social Security - -	
Occupation		Employer		Employer Phone Number	
<b>Employment Status:</b> <input type="checkbox"/> 1 – Full-Time <input type="checkbox"/> 2 – Part-Time <input type="checkbox"/> 3 – Not Employed <input type="checkbox"/> 4 – Self-Employed <input type="checkbox"/> 5 – Retired <input type="checkbox"/> 6 – Active Military <b>Student Status:</b> <input type="checkbox"/> F – Full-Time Student <input type="checkbox"/> P – Part-Time Student <input type="checkbox"/> N – Not a Student					
<b>Race:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Declined <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined <b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other _____					
<b>Pharmacy:</b>			Do you have a living will? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Referred By ( Please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____					
Other Family Members Seen Here					
PCP Name			Phone #		
RESPONSIBLE PARTY INFORMATION			(information used for patient balance statements)		
Responsible Party: <input type="checkbox"/> Another Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Self			<input type="checkbox"/> Check here if information is same as patient		
Name		Address		Home Phone Number	
Birth Date / /		E-Mail Address		( )	
Occupation		Employer		Employer Address	
				Employer Phone Number ( )	
INSURANCE INFORMATION			(provide your insurance card to the front desk at check-in)		
Is this visit for one of the following? <input type="checkbox"/> WORKERS COMPENSATION (WC) <input type="checkbox"/> OCCUPATIONAL MEDICINE (OM) <input type="checkbox"/> MOTOR VEHICLE ACCIDENT (MVA) <input type="checkbox"/> ACCIDENT DATE _____					
Does the patient have healthcare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO			Insurance Name		
Name of Insured		Social Security Number - -	Birth Date / /	Effective Date / /	Group ID
				Subscriber ID (Policy Number)	
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance		Name of Insured		Date of Birth / /	Group ID
				Subscriber ID (Policy Number)	
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
EMERGENCY CONTACT					
Name (Last, First)		Relationship to Patient		Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

# CLARK ORTHOPEDIC & SPINE

Norton Healthcare  
and LifePoint Health

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

What body part are we seeing you for today: \_\_\_\_\_ RIGHT [ ] or LEFT [ ]

Is visit due to an Injury, a Work Accident, or a MVA? [ ] YES [ ] NO Name of any other MD's you have seen for this \_\_\_\_\_

Date symptoms started: \_\_\_\_\_ How did it happen? \_\_\_\_\_

What treatment or tests have you had for this current problem? [ ] Surgery [ ] Injection [ ] Splint/Brace [ ] Physical Therapy  
[ ] X-Ray [ ] MRI [ ] CT Scan [ ] EMG [ ] Medication: \_\_\_\_\_

Where were x-ray or testing done at? \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Right Handed [ ] or Left Handed [ ]

### Medical History and Impairments (check box if YES)

Allergies _____ [ ]	Lung Disease _____ [ ]	Anesthetic Complications _____ [ ]	MRSA/Staph _____ [ ]
Anemia _____ [ ]	Depression _____ [ ]	Nerve/Muscle Disease _____ [ ]	Thyroid Disease _____ [ ]
Anxiety _____ [ ]	Diabetes Mellitus _____ [ ]	Osteoporosis _____ [ ]	Kidney Disease _____ [ ]
Arthritis _____ [ ]	Acid Reflux _____ [ ]	Seizures _____ [ ]	Tuberculosis _____ [ ]
Asthma _____ [ ]	Gout _____ [ ]	Stroke _____ [ ]	Ulcers _____ [ ]
Blood Transfusion _____ [ ]	Cancer _____ [ ]	Heart Attack _____ [ ]	Substance Abuse _____ [ ]
Hepatitis _____ [ ]	HIV/AIDS _____ [ ]	High Blood Pressure _____ [ ]	High Cholesterol _____ [ ]
Congestive Heart Failure _____ [ ]	Clotting Disorder (i.e., blood clot) _____ [ ]	Brain Damage _____ [ ]	Canavan Disease _____ [ ]
Attention Deficit Disorder _____ [ ]	Autistic Disorder _____ [ ]	Balance Disorder _____ [ ]	Blindness _____ [ ]
Cerebral Palsy _____ [ ]	Cystic Fibrosis _____ [ ]	Deafness _____ [ ]	Down Syndrome _____ [ ]
Epilepsy _____ [ ]	Head Injury _____ [ ]	Hearing Loss _____ [ ]	Mood Disorder _____ [ ]
Movement Disorder _____ [ ]	Multiple Sclerosis _____ [ ]	Muscular Dystrophy _____ [ ]	Neurological Disorder _____ [ ]
Paraplegia _____ [ ]	Deafness _____ [ ]	Personality Disorder _____ [ ]	Psychiatric Disorder _____ [ ]
Tay-Sachs Disease _____ [ ]	Vision Impairment _____ [ ]	Any Other Medical History: _____	

### Surgical History (check box if YES and list YEAR of surgery on line)

Appendix _____ [ ]	Brain Surgery _____ [ ]	Breast Surgery _____ [ ]	Open Heart or Bypass _____ [ ]
Gallbladder _____ [ ]	Colon _____ [ ]	Cosmetic Surgery _____ [ ]	C-Section _____ [ ]
Eye Surgery _____ [ ]	Surgical Repair of Fracture _____ [ ]	Hernia Repair _____ [ ]	Hysterectomy _____ [ ]
Joint Replacement _____ [ ]	Arthroscopy _____ [ ]	Spine Surgery _____ [ ]	Tubes Tied _____ [ ]
Tonsils/Adenoids _____ [ ]	Weight Loss Surgery _____ [ ]	Any Other Surgeries: _____	

**Social History:**

**Tobacco Use:** Never Smoker [ ] Current Smoker [ ] *Packs per day* \_\_\_\_\_ Former Smoker [ ] *Year Quit* \_\_\_\_\_

**Alcohol Use:** Beer [ ] Wine [ ] Liquor [ ] **Drinks per week** \_\_\_\_\_

**Drug Use:** Marijuana [ ] Cocaine [ ] Methamphetamines [ ] IV Drug [ ] **Number of times per week** \_\_\_\_\_

**Current Medications (Prescription and Over the Counter (IF YOU HAVE A LIST PLEASE PROVIDE TO FRONT DESK INSTEAD OF WRITING OUT))**

- |           |           |           |
|-----------|-----------|-----------|
| 1. _____  | 2. _____  | 3. _____  |
| 4. _____  | 5. _____  | 6. _____  |
| 7. _____  | 8. _____  | 9. _____  |
| 10. _____ | 11. _____ | 12. _____ |
| 13. _____ | 14. _____ | 15. _____ |

**Medication Allergies (including Latex):** [ ] NO or [ ] YES \_\_\_\_\_

**Family Medical History** Instructions: Please check the box of positive family medical history **KEY: Paternal= Father's Side Maternal= Mother's Side**

	Cancer	Diabetes	Arthritis	Heart Disease	High Blood Pressure	Stroke	Anemia	Osteoporosis
Mother	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Father	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Sister	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Brother	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Maternal GM	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Maternal GF	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Paternal GM	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Paternal GF	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Maternal Aunt	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Maternal Uncle	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Paternal Aunt	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Paternal Uncle	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

**Review of Systems (Please check box if you are currently experiencing any of the following conditions)**

Fever_____ [ ]	Weight Loss_____ [ ]	Blurred Vision_____ [ ]	Ringling in Ears_____ [ ]	Sore Throat_____ [ ]
Chest Pain____ [ ]	Difficulty Breathing__ [ ]	Abdominal Pain_____ [ ]	Change in Bowel Habits_ [ ]	Burning on Urination__ [ ]
Blood in Urine_ [ ]	Skin Color Changes__ [ ]	Rash_____ [ ]	Breast Lumps_____ [ ]	Headache_____ [ ]
Fainting_____ [ ]	Dizziness_____ [ ]	Seizure_____ [ ]	Swelling in Neck_____ [ ]	Easy Bleeding_____ [ ]
Easy Bruising__ [ ]	Appetite Change_____ [ ]	Change in Energy Level_ [ ]	Drastic Mood Swing____ [ ]	Other_____

**What activities are you currently involved in? (Please check box for all that apply)**

Blading_____ [ ]	Boating_____ [ ]	Community Service___ [ ]	Community Sports _____ [ ]	Community Club_____ [ ]
Computers_____ [ ]	Dance_____ [ ]	Debate_____ [ ]	Drama_____ [ ]	Golf_____ [ ]
Gymnastics_____ [ ]	Instrumental Music [ ]	Martial Arts_____ [ ]	Pets/Animals_____ [ ]	Reading _____ [ ]
Religious Activities___ [ ]	Riding_____ [ ]	Sailing_____ [ ]	School Club _____ [ ]	School Sports _____ [ ]
Tennis_____ [ ]	Vocal Music [ ]	Weight Training_____ [ ]	Water/Winter Sports___ [ ]	
Other_____		None_____ [ ]		

**Do you have any other doctors involved in your care? (Please list all below)**

Primary Care Physician\_\_\_\_\_

Allergist\_\_\_\_\_

Cardiologist\_\_\_\_\_

Endocrinologist\_\_\_\_\_

Neurologist\_\_\_\_\_

OBGYN\_\_\_\_\_

Oncologist\_\_\_\_\_

Ophthalmologist\_\_\_\_\_

Orthopedic Surgeon\_\_\_\_\_

Pain Management\_\_\_\_\_

Rheumatologist\_\_\_\_\_

Other\_\_\_\_\_

**HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY**

**I. CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

**II. NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

\_\_\_\_\_  
Patient  
Initials

The patient understands that:

- The Clark Medical Group has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me. This contract form is for all physician services/practices within Clark Medical Group and expires 1 calendar year from date form signed and dated.

NAME	RELATIONSHIP	CONTACT NUMBER

**III. ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related

information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

- IV. PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.
- V. EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.
- VI. FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

**VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

\_\_\_\_\_  
Printed Name of Patient or Representative

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

Relationship to Patient (if other than patient) \_\_\_\_\_

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**CLINIC STAFF USE ONLY**

Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
Witness (Staff) Signature

\_\_\_\_\_  
Witness (Staff) Printed Name

Date: \_\_\_\_\_