PROVIDENCE
Health & Services

www.california.providence.org

REGISTRATION FORM

Today's Date: _____ Referring MD: _____

Patient Name (last, first, middle): _____

Sex: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN#: _____ DOB: _____

Home Phone #: _____ Cell Phone #: _____

Driver's License#: _____ Email address: _____

Occupation: _____ Employment Status: _____

Employer: _____ Work Phone #: _____

Spouse Name: _____ Spouse SSN#: _____

INSURANCE INFORMATION

Subscriber Name: _____ Secondary Insurance (if applicable): _____

Subscriber SSN#: _____ Subscriber Name: _____

Birthdate: _____ Subscriber SSN#: _____

Group # _____ Group # _____

Policy #: _____ Policy #: _____

Co-Payment $: _____ Co-Payment $: _____

Patient's Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Patient's Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other: _____

REGISTRATION FORM (CONTINUED)

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship to Patient: _____

Phone #: _____ Work Phone #: _____

Other Phone #: _____

MEDICARE PATIENTS

I authorize payment directly to the physician services and benefits for
Accept Assignment services: all other services are responsibility of the patient.

Patient Signature: _____ Date: _____

PRIVATE INSURANCE / SELF PAY PATIENTS

We will be happy to bill your insurance; All services not covered by insurance are the financial responsibility of the patient, however you are responsible for any co-payment or co-insurance at the time of service.

Patient Signature: _____ Date: _____

CENTER FOR ORTHOPAEDIC SPECIALISTS
PROVIDENCE
www.cos-orthopaedics.com

HEALTH QUESTIONNAIRE

DATE COMPLETED:_____

NAME_____ AGE_____ SEX: Male / Female

OCCUPATION_____ EMPLOYER_____

MARITAL STATUS: Single / Married / Divorced / Widowed / Domestic Partner

HEIGHT_____ WEIGHT_____ BIRTHDATE_____ DOMINANT HAND: Left / Right

SPORTS & HOBBIES:_____

NAME OF YOUR PRIMARY CARE PHYSICIAN (INTERNIST OR PEDIATRICIAN):_____

DRUG ALLERGIES: ☐ **NONE** OR LIST:_____

TOBACCO: ☐ NEVER SMOKED ☐ FORMER SMOKER DATE QUIT?: _____
☐ CURRENT SMOKER # PACKS / PER DAY _____ E-CIGARETTE: ☐ YES ☐ NO

ALCOHOL: ☐ NONE ☐ RECOVERING ALCOHOLIC ☐ YES, # OF DRINKS PER WEEK _____ / PER MONTH _____

SUBSTANCE/DRUG ABUSE: ☐ YES ☐ NO ☐ PRIOR HISTORY.....PLEASE LIST: _____

In the event an X-Ray is ordered or certain medication is recommended: _____

Are you currently pregnant?: ☐ Yes ☐ No Date of your last menstrual period: _____
History of: ☐ Hysterectomy ☐ Menopause ☐ Premenopause ☐ Postmenopause

PLEASE LIST YOUR CURRENT MEDICATIONS

(Please include over the counter, vitamins/supplements)

Medication(s):		Reason for use of the Medication(s):	
1)_____	6)_____	1)_____	6)_____
2)_____	7)_____	2)_____	7)_____
3)_____	8)_____	3)_____	8)_____
4)_____	9)_____	4)_____	9)_____
5)_____	10)_____	5)_____	10)_____

Pharmacy Name:_____ City/Zip Code:_____

Please list your other physician specialists below.

_____

_____

How were you referred to our practice?

☐ Physician Referral:_____ Tel:_____

☐ Internet ☐ Friend/Family

☐ Other:_____

(e.g. Physical Therapist, Home Health Agency, Vendor, Specialists, Walk-in, etc.)

PAST SURGERIES: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

_____

_____

ILLNESSES: ☐ **NONE** – OR LIST:

_____

_____

INJURIES/HOSPITALIZATIONS: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

_____

FAMILY HISTORY: PLEASE CHECK:

Do you or your family have any history of Osteoarthritis (Arthritis) ☐ YES ☐ NO and/or Osteoporosis ☐ YES ☐ NO

SYSTEM REVIEW: PLEASE CHECK IF YOU HAVE/HAD ANY OF THESE CONDITIONS:

GENERAL: ☐ **HEALTHY** ☐ ILL ☐ RECENT WEIGHT GAIN _____ LBS., LOSS _____ LBS.
☐ PREGNANT

HEART: ☐ **NORMAL** ☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK ☐ ARRHYTHMIA
☐ HEART FAILURE ☐ CORONARY ARTERY DISEASE ☐ HIGH CHOLESTEROL

VASCULAR: ☐ **NORMAL** ☐ ARTERIAL INSUFFICIENCY ☐ VARICOSE VEINS
☐ CAROTID ARTERY ☐ LEG SWELLING ☐ PHLEBITIS

LUNGS: ☐ **NORMAL** ☐ ASTHMA ☐ CHRONIC LUNG DISEASE ☐ C.O.P.D.
☐ BLOOD CLOTS IN LUNG / P.E. ☐ PNEUMONIA

GASTROINTESTINAL: ☐ **NORMAL** ☐ HEARTBURN / REFLUX ☐ PEPTIC ULCER ☐ LIVER DISEASE
☐ HEPATITIS A / B / C ☐ OTHER:_____

URINARY TRACT: ☐ **NORMAL** ☐ BLADDER INFECTION ☐ PROSTATE ENLARGMENT
☐ FREQUENT URINATION ☐ KIDNEY STONES ☐ KIDNEY FAILURE

ENDOCRINE: ☐ **NORMAL** ☐ DIABETES ☐ HYPOTHYROIDISM ☐ HYPERTHYROIDISM
☐ OTHER:_____

HEMATOLOGIC: ☐ **NORMAL** ☐ BLOOD CLOTS / D.V.T. ☐ ABNORMAL BLEEDING TENDENCIES
☐ BLOOD TRANSFUSION – (☐ YOUR OWN BLOOD, OR ☐ DONOR BLOOD)

NEUROLOGIC: ☐ **NORMAL** ☐ STROKE ☐ SEIZURES ☐ M.S. ☐ DEPRESSION

MUSCLES & JOINTS: ☐ **NORMAL** ☐ OSTEOARTHRITIS ☐ GOUT ☐ FIBROMYALGIA
☐ RHEUMATOID ARTHRITIS ☐ OTHER:_____

HEAD & NECK: ☐ **NORMAL** ☐ VISUAL LOSS ☐ SINUS PROBLEMS ☐ HEARING LOSS
☐ HEADACHE ☐ OTHER: _____

SKIN: ☐ **NORMAL** ☐ CANCER ☐ PSORIASIS ☐ ECZEMA ☐ RASHES

INFECTIOUS DISEASE: ☐ **NORMAL** ☐ HEPATITIS A / B / C ☐ HIV ☐ TUBERCULOSIS ☐ M.R.S.A.

CANCER: ☐ **NONE** ☐ YES, TYPE: _____

BONES: ☐ **NORMAL** ☐ OSTEOPENIA ☐ OSTEOPOROSIS
☐ FRACTURES, IF YES, WHICH BONES? _____

_____

PLEASE USE THE SPACE BELOW TO EXPLAIN WHY YOU ARE SEEING THE DOCTOR

Date of onset of your current condition:_____

Was your condition caused by an injury? ☐ Yes ☐ No

SCALE OF PAIN, TODAY: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

(Circle One #) NO PAIN MODERATE WORST PAIN POSSIBLE