COLLEGE STUDENT PATIENT REGISTRATION

KEUKA COLLEGE/HOBART AND WILLIAM SMITH COLLEGES

Please print all requested information

Sports-Related Injury: YES NO Date of Injury: _______________

Patient Information: Male: _____ Female: _____

Patient's Legal Name: ____ Soc Sec #:_______________
First MI Last

Address: ____ Date of Birth: ____________
At school Street City State Zip

Home Address: ____ Home Phone #:(__)________
Street City State Zip

Cell Phone #: (__) ____________________ Phone # at school: (__)_______________

Mother's name and address: ____ DOB: __________________

Father's name and address: ____ DOB: __________________

Insurance Information: (please provide your insurance card to the receptionist)

Name of Primary Insurance Carrier: ________________________________ Ins ID#: ________________
Subscriber Name (if different than patient):_____________________________ DOB: __________________
Address: ____ Relationship: ____________

Name of Secondary Insurance Carrier: ______________________________ Ins ID#: ________________
Subscriber Name (if different than patient): ___________________________ DOB: __________________
Address: ____ Relationship: ____________

Authorizations:

I hereby authorize release of information in relation to medical treatment by **Interlakes Orthopaedic Surgery** to the insurance carriers, or others who are financially liable for my medical care all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date Signature of patient or authorized representative

I hereby assign to **Interlakes Orthopaedic Surgery** sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or to others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

Date Signature of patient or authorized representative

I have read the Payment Policy of **Interlakes Orthopaedic Surgery, P.C.,** effective 01/01/08, and agree to abide by the provision of the policy.

Date Signature of patient or authorized representative

Interlakes Orthopaedic Surgery

Chart #

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your consent. Thank you very much for taking the time to fill out this form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit. Thank You

Name: **Birthdate:** **Age:**

Primary Care Physician: Referring Physician:

What brings you to see the doctor today? **(Please be specific.)**

Date of injury (if injury): **Body part involved:**

Hospital / Surgical History: ☐ None

Illness or Operation	Date	Illness or Operation	Date
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Do you have any of the following:

☐ Artificial Joint ☐ Other Prosthesis/Implant ☐ Pacemaker
☐ Artificial Limb If yes, what ______________________________ ☐ Defibrillator

Allergies: ☐ None Are you allergic to **LATEX**? YES ☐ NO ☐

Please list any medications, dyes, food, contact or environmental substances to which you have had an allergic or bad reaction.

Medications: ☐ None

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

1)	5)	9)
2)	6)	10)
3)	7)	11)
4)	8)	12)

Past Medical History: (check those that apply to you)

☐ Pneumonia	☐ Bronchitis	☐ Anemia	☐ Ulcers	☐ GERD/Hiatal hernia
☐ High Blood Pressure	☐ Emphysema	☐ Hepatitis/Jaundice	☐ Depression	☐ Hypothyroid
☐ Stroke	☐ Seizures	☐ Phlebitis/Blood Clots	☐ Bleeding Disorders	☐ Sickle Cell disease
☐ Glaucoma	☐ HIV Positive	☐ Thyroid Disorder	☐ Cancer	☐ High Cholesterol
☐ Asthma	☐ Heart Attack	☐ Arthritis	☐ Angina	☐ Enviromental allergies
☐ Tuberculosis	☐ Diabetes	☐ Kidney Disease	☐ Heart Murmur	

Women Only: Last Pap Smear: Last Mammogram: Last Bone density:

Family History Is there a history of any of the following in your family? **(Check those that apply)**

☐ Diabetes	☐ Kidney Disease	☐ High Blood Pressure
☐ Heart Disease	☐ Arthritis	☐ Sickle Cell disease
☐ Cancer	☐ Bleeding Problems	☐

Social History:

Occupation: Date last worked: Marital Status:

Do you exercise regularly?	YES	NO	What type?	How often?
Have you ever smoked?	YES	NO	I currently smoke ________ packs per day.	I have smoked for years.

I formerly smoked but stopped in: (list year)

Do you use other forms of tobacco?	YES	NO	Do you use illicit drugs?	YES	NO	Do you drink alcohol?	YES	NO
How often/how much?			How often/how much?			How often/how much?		

Have you ever been exposed to anyone with tuberculosis?	YES	NO	
Are you currently experiencing unusual stress?	YES	NO	Explain:

Recent diagnostic testing

(Please include any tests performed within the past year, ie: lab tests, x-rays, cardiac tests, **colonoscopy**, etc.)

Test	Date	Where	Test	Date	Where

Please check all conditions you have now or in the past:

Gastrointestinal ❐None

- ◻ Poor appetite
- ◻ Nausea
- ◻ Vomiting
- ◻ Difficulty swallowing
- ◻ Pain in swallowing
- ◻ Heartburn
- ◻ Indigestion

Ulcer

- ◻ Stomach
- ◻ Duodenum
- ◻ Internal bleeding
- ◻ Belly pain

____

____

- ◻ Gall bladder problems
- ◻ Liver problems
- ◻ Jaundice
- ◻ Hepatitis

Bowels

- ◻ Regular
- ◻ Irregular
- ◻ Constipation

General ❐None

- ◻ Weight loss
- ◻ Weight gain

Genitourinary ❐**None**

- ◻ Blood in Urine
- ◻ Urinating frequently
- ◻ Burning/pain with urination

Respiratory ❐None

- ◻ Wheezing
- ◻ Prolonged cough
- ◻ Coughing up blood
- ◻ Emphysema

Shortness of breath

- ◻ Waking up
- ◻ Lying down
- ◻ Other -

Eyes ❐None

- ◻ Glaucoma
- ◻ Double vision
- ◻ Blurred vision
- ◻ Glasses/contacts

Skin ❐None

- ◻ Excessive sweating
- ◻ Oily skin
- ◻ Dry skin

Neuro & Psyc ❐None

- ◻ Anxiety
- ◻ Headaches
- ◻ Depression
- ◻ Seizures
- ◻ Memory Loss
- ◻ Head injuries
- ◻ Blackouts
- ◻ Change in sensation
- ◻ Localized weakness
- ◻ **Claustrophobia**

Endocrine ❐None

- ◻ Changes in skin texture
- ◻ Cold intolerance
- ◻ Heat intolerance
- ◻ History of diabetes
- ◻ Excessive thirst

Ears/Nose/Throat ❐None

- ◻ Hoarseness
- ◻ Ringing in your ears
- ◻ Hay fever
- ◻ Sinus infections
- ◻ Goiter
- ◻ Ear Infections
- ◻ Hearing Loss
- ◻ Frequent nosebleeds

Cardiovascular ❐None

- ◻ Angina/chest pain
- ◻ High/low blood pressure
- ◻ Ankle swelling
- ◻ Murmurs
- ◻ Irregular heart rate
- ◻ Heart palpitations
- ◻ Leg cramps
- ◻ Leg pain with walking

Height ___________

Weight __________

Patient Signature:

Nurse Review:

History of Present Illness: (*To be completed by physician* **.)**

(Sign & date)

Physician Signature

Date