GITELIS ORTHOPEDICS
MINIMALLY INVASIVE SURGERY & REGENERATIVE MEDICINE

Patient Registration

Patient Demographics

Name: _____

Birthdate:_____/_____/_____ **Age:**_____ **SS#**_____

Street Address: _____

City:_____ **State:**_____ **Zip:** _____

Home Phone: _____ **Marital Status:**_____

Cell Phone:_____ **Email:** _____

Work Phone: _____

***Please circle primary phone number*

Patient (Emergency) Contact: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

How did you hear about/find Dr Gitelis?_____

Pharmacy

Name:_____

Phone:_____

Address:_____

_____

Primary Care Physician

Name:_____

Phone:_____

Address:_____

_____

Employment

Name Of Employer:_____

Address:_____

Phone # :_____

Coverage(s)

Primary Insurance

Payor/Insurance Company: _____

Group Number:_____**Subscriber ID:** _____

Patient Relationship to Subscriber: _____

Name of Subscriber: _____

Birthdate of Subscriber:_____

Secondary Insurance

Payor/Insurance Company: _____

Group Number:_____**Subscriber ID:** _____

Patient Relationship to Subscriber: _____

Name of Subscriber: _____

Birthdate of Subscriber:_____

Work Related? YES NO

Work Comp Carrier_____

Claim Number_____

Address_____

Work Comp Contact_____

Contact Phone Number_____

Needs Interpreter? YES NO

Preferred Language:_____**Written Language:**_____

Race:_____**Ethnicity: Hispanic / Not Hispanic (please circle one)**

Medical History Form Date: _____

PATIENT INFORMATION:

Name_____
(First) (Middle) (Last)

Age: _____ **Date of Birth:** _____ **Gender:** M F

Right or Left Handed? _____

Occupation: _____

REFERRING PHYSICIAN:

Name: _____
(First) (Last)

Phone: _____

Working Status: (Circle one) Working Retired Disabled

Chief Complaint: (Example: Right hip pain) _____

Date of injury or onset of symptoms: ____/____/_____

Describe your symptoms: (Example, a sharp pain when I walk.)_____

_____

How did injury happen? _____

_____

Symptom Relief: (e.g. rest, heat/cold, therapy, medication) _____

Symptom Aggravation: (e.g. activity, movement) _____

Additional Symptoms: _____

Describe Treatment: _____

Have you had any diagnostic tests for this problem? Yes No **If yes, what & where?** _____

Has a physician recommended that you have surgery for this problem? Yes No

Name of previous treating physician(s), if any? _____

PAST MEDICAL HISTORY:

_____

_____

_____

PAST SURGICAL HISTORY: (Please list the surgical procedure, date of procedure and complications.)

_____

_____

_____

Have you ever had problems with anesthesia? Yes No If yes, please describe: _____

SOCIAL HISTORY:

Student: Yes No School? _____ Grade: _____ Sport: _____

Marital Status: Single / Married / Divorced / Widowed Do you live alone? _____

Alcohol use: Never / Occasional / Daily / Heavy History of alcoholism? Yes No History of drug use? Yes No

FAMILY HISTORY:

_____

_____

_____

MEDICATIONS: (Prescription / Nonprescription / Herbal supplements / Vitamins / Other)

Medication Name	**Dosage**	**Medication Name**	**Dosage**

Medical History Form Date: _____

_____
_____
_____
_____

Have you had a DEXA Scan? Yes No **Date of DEXA?**_____

Are you taking: Low-dose aspirin? Yes No **Anti-coagulants?** Yes No **Corticosteroids?** Yes No

Have you taken at least two different anti-inflammatory medications for your condition? Yes No If yes, how long?_____

ALLERGIES: Please list type of allergy (medications, latex, metals, etc) and type of reaction you experience:

_____
_____
_____

RISK FACTORS:

Tobacco Use: (Circle One) Never Smoked Former Smoker Current Smoker

Height: _____ **Weight:** _____ **BP:** __________

REVIEW of SYSTEMS: Have or do you ever experience any of the following signs or symptoms? If yes please describe.

	Yes	**No**	**Describe all "Yes" responses**
Eyes (e.g. blurred vision, double vision, loss of vision)	Yes	No	_____
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	Yes	No	_____
Cardiovascular (e.g. chest pain, palpitations)	Yes	No	_____
Respiratory (e.g. shortness of breath, cough, snore)	Yes	No	_____
Gastrointestinal (e.g. ulcer, gastritis, GI bleed)	Yes	No	_____
Genitourinary (e.g. burning, bleeding)	Yes	No	_____
Musculoskeletal (e.g. joint, muscle, back or neck pain)	Yes	No	_____
Skin (e.g. delayed healing, rash, acne, cellulitis)	Yes	No	_____
Neurological (e.g. numbness, tingling, weakness)	Yes	No	_____
Endocrine (e.g. weight gain/loss, excess thirst or urine)	Yes	No	_____
Hematologic (e.g. bruising, bleeding, clotting disorder)	Yes	No	_____
Allergic / Immunologic (e.g. rash, swelling, wheezing)	Yes	No	_____

Comments or Clarification: _____

_____

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

_____ ___/___/_____
Patient Signature

_____ __/___/_____
Guardian Signature

_____
Guardian/Authorized Representative Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.

Any Changes

Yes / No _____ __/___/____
Signed Date

Yes / No _____ __/___/____
Signed Date

Yes / No _____ __/___/____
Signed Date

PLEASE SIGN & DATE:

Gitelis Orthopedics Privacy Policy has been made available to me in the office:

X_____Date:_____

Patient Signature (Parent if patient is a minor)

CONFIDENTIAL COMMUNICATION REQUEST

May we leave a message regarding medical information, please circle your answer:

On answering machine at home?	Yes	No
With person at your home?	Yes	No
On your voicemail at work?	Yes	No
On your email account?	Yes	No
In a cell phone text message?	Yes	No

May we speak to a family member regarding your medical status? If so, with whom may we speak?

_____

X_____ Relationship: Phone #:

Patient Signature (Parent if patient is a minor)

May we speak to a family member regarding your financial status? If so, with whom may we speak?

_____

X_____

Patient Signature (Parent if patient is a minor)

RELEASE OF LABORATORY & X-RAY INFORMATION

I hereby authorize Gitelis Orthopedics to give lab, X-Ray, MRI, and CT results to a family member:

X_____

Patient Signature (Parent if patient is a minor)

ACKNOWLEDGEMENT REGARDING MEDICAL EQUIPMENT/MEDICAL SERVICES

Not all medical equipment and/or services may be paid for by my insurance company. We will try to let you know which items may not be covered. If my Insurance Carrier denies payment, I agree to be personally and fully responsible for payment.

X_____

Patient Signature (Parent if patient is a minor)

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Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Gitelis Orthopedics for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Gitelis Orthopedics.

I have the right to revoke this consent, in writing, at any time, except to the extent that Gitelis Orthopedics has taken action in reliance on this consent

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Gitelis Orthopedics Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Gitelis Orthopedics. The Notice of Practice Practices Gitelis Orthopedics is also provided in the reception area and on the group website at This Notice of Privacy Practices also describes my rights and the Gitelis Orthopedics duties with respect to my health information.

Electronic Format: I acknowledge that my records are stored in an electronic format. I understand Gitelis Orthopedics maintains their patient records in electronic format only. Original documents are destroyed after being converted to an electronic format.

Gitelis Orthopedics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by obtaining a copy at my next appointment or requesting one be sent in the mail. I acknowledge I have received a copy of the Notice of Privacy Practices.

_____
Name and relationship to patient

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____

Parent or Personal Representative refused to sign acknowledgement
_____Staff Initials
_____Date