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OSC
ORTHOPAEDIC AND SPORTS MEDICINE CENTER
-Norman, P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____ **Sex: Male Female**
First Middle Last

DOB: _____ **Age:** _____ **SS#:**_____-_____-_____ **Cell Phone #:** (_____)_____
Month/Day/Year

Address: _____ **Email:**_____
(If P.O. Box, please also list street number) City State Zip

Employer: _____**Alternate Phone #:** (_____)_____

Primary Care Doctor:_____ **Doctor/Facility who referred you to OSC:**_____

PARENT/GUARDIAN OR PERSON RESPONSIBLE FOR BILL

Name: _____ **SS #:** _____-_____-_____ **DOB:** _____
First Middle Last

Relationship to Patient: ____**Parent** ____**Legal Guardian** *(please submit documentation)* ____**Other:**_____

Address:_____ **Cell Phone:** (_____)_____
(If P.O. Box, please also list street number) City State Zip

Employer: _____ **Work Phone:** (_____)_____

IN CASE OF EMERGENCY

Emergency contact person outside your home: _____

Relationship to Patient: _____ **Phone:** (_____)_____

Address _____
Street City State Zip

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #:_____ **Policy #:** _____

SECONDARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #: _____ **Policy #:** _____

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome or AIDS. I further authorize the insurance company listed above to make payment directly to Orthopaedic Sports Medicine Center-Norman, P.C. for services regarding this illness or injury. I understand that I am financially responsible for payment of all charges. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a company of this medical practice's Notice of Privacy Practices.

I further acknowledge that I will be offered a copy of an amended Notice of Privacy Practices at each appointment.

Requested Restrictions_____

Print Name: _____ **Relationship to Patient:** _____

Patient's Signature (or parent/guardian if minor): _____ **Date:** _____

Effective 11/17/2016
Revised 05/01/2020

HIPAA Authorization Release Form

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information: (Check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases)including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify) _____
    _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reason.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

_____
Printed Name of Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

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PATIENT MEDICAL HISTORY FORM

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____

First *Last*

Current Pharmacy:_____

Name *City* *State*

List All Medications that you are currently taking: ☐ **None**

Medication	*Strength*	*Quantity*	*Frequency*

List any medication allergies: ☐ **None** _____

_____

List all past surgeries: ☐ **None**

Surgery	*Year*

List all hospitalizations: ☐ **None**

Reason for hospitalization	*Year*

Updated 11-02-2020

Patient's Name: _____ **DOB:** _____

First *Last*

FAMILY HISTORY: ☐ **Unknown**

Number of Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

Check the box for those medical histories that apply:

Member	Status	YOB	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Anesthetic Reaction	Unknown
Father	☐ Alive ☐ Deceased										
Mother	☐ Alive ☐ Deceased										
Siblings	☐ Alive ☐ Deceased										
Siblings	☐ Alive ☐ Deceased										
Siblings	☐ Alive ☐ Deceased										
Siblings	☐ Alive ☐ Deceased										

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes Approximate number per day: _____

Are you pregnant? ☐ N/A ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you drink alcohol? ☐ Never ☐ Monthly or less ☐ Two to four times a month ☐ Two to Three times per week ☐ Four or more times per week

Do you exercise regularly? ☐ No ☐ Yes Times per week: _____

Have you traveled outside the U.S. in the past 10 years? ☐ No ☐ Yes

Have you ever used recreational drugs? ☐ No ☐ Yes

PAST MEDICAL HISTORY (check all medical conditions that apply):

☐ No history of medical conditions

☐ No new medical conditions since last visit

Acid reflux	☐	Gout	☐
Allergies Seasonal	☐	Heart Disease	☐
Anemia	☐	Hepatitis	☐
Anxiety	☐	High Blood Pressure	☐
Asthma	☐	HIV	☐
Bleeding Disorder	☐	Osteoarthritis	☐
Blood Clot	☐	Osteoporosis	☐
Diabetes Type I	☐	Rheumatoid Arthritis	☐
Diabetes Type II	☐	Seizures	☐
Emphysema	☐	Thyroid Disease	☐
Gastroesophageal Reflux Disease (GERD)	☐		
Glaucoma	☐		

Other:_____

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ORTHO PATIENT MEDICAL FORM

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____

First *Last*

CURRENT MEDICAL HISTORY (check all of the medical symptoms that you are currently experiencing):

Constitutional:
- Fatigue ☐
- Fever ☐

HEENT:
- Hoarseness ☐
- Nose Bleed ☐

Cardiology:
- Chest Pain ☐
- Shortness of breath ☐
- Swelling of ankles ☐

Neurology
- Headache ☐
- Loss of feeling in legs ☐
- Numbness ☐
- Seizures ☐

Respiratory
- Blood-tinged sputum ☐
- Cough ☐
- Wheezing ☐

Gastroenterology
- Abdominal pain ☐
- Black stools ☐
- Blood in stools ☐
- Heartburn ☐
- Nausea ☐

Hematology/Lymph
- Abnormal bleeding ☐

Musculoskeletal
- Bone pain ☐
- Joint stiffness ☐
- Joint pain ☐
- Joint swelling ☐
- Joint redness ☐
- Leg cramps ☐
- Muscle pain ☐
- Muscle stiffness ☐

Psychology:
- Depression ☐

Urology:
- Blood in urine ☐
- Recurrent UTI ☐

Dermatology:
- Rash ☐

None of the above ☐