Department of Orthopaedic Surgery: Sports Medicine

Patient Registration Form

MASSACHUSETTS GENERAL HOSPITAL
ORTHOPAEDICS

Name: _____ Date: _____

Age: _____ Sex: ☐ M ☐ F Occupation: _____

Referred by Dr _____

Referring Physician's Address: _____

Chief Complaint: _____

General Health: (check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications: ☐ None or below list medications you are taking

_____ for _____

_____ for _____

_____ for _____

Allergies: ☐ None (Reaction due to allergy)

Allergic to Penicillin _____

Allergic to sulfa drugs _____

Allergic to _____

Prior surgical procedures and hospitalizations (include dates):

_____

_____

Review of Systems (check symptoms you have) and describe:

Constitutional (☐ fever, ☐ weight loss, etc.) _____

Eyes (☐ double vision, ☐ blurring, ☐ glasses) _____

ENT, Mouth (☐ deafness, ☐ sinusitis, ☐ dizziness) _____

Heart (☐ chest pain, ☐ murmur, ☐ irregular beats) _____

Circulation (☐ high blood pressure) _____

Respiratory (☐ asthma, ☐ shortness of breath, ☐ cough) _____

GI (☐appetite, ☐ diarrhea, ☐ constipation) _____

Urinary (☐ problem urinating, ☐ incontinence) _____

GYN (☐ menstrual problems, ☐ pregnancies) _____

Musculoskeletal (☐ arthritis, ☐ stiffness) _____

Skin (☐ acne, ☐ rash) _____

Breast (☐ lump) _____

Neurological (☐ seizures, ☐ weakness, ☐ balance) _____

Psychiatric (☐ depression, ☐ mood liability, ☐ other) _____

Endocrine (☐ thyroid problems) _____

Hematologic (☐ bleeding tendency, ☐ anemia) _____

Lymphatic (☐ enlarged lymph nodes) _____

Allergy (☐ hay fever, ☐ dermatitis) _____

Weight _____ Height _____

Family History

Are there any illnesses that run in the family? _____

Diabetes? _____ Bleeding problems? _____

Anesthesia problems? _____

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children & ages _____

Tobacco use _____ Packs per day ____ Number of years _____

Alcohol use _____ Drug use _____ Exposure to Hepatitis or AIDS? ☐ Yes ☐ No

Living Situation: _____

Reviewed by Dr. _____

***MUST COMPETE ENTIRE FORM INCLUDING INSURANCE, PCP, DATE OF BIRTH ***

PATIENT NAME: _____
First name Middle initial Last name

DOB: ____/____/____ MGH unit #: _____ Social Security #: _____

Street address: _____ Home phone: _____

City: _____ State & Zip Code: _____ Work phone: _____

E-Mail address: _____ Cell phone: _____

Parent name (if patient is a child): _____ Spouses' name: _____

In case of emergency, please notify: _____ Phone: _____

PRIMARY INSURANCE INFORMATION (if Workers Comp or MVA please speak with secretary)

Insurance carrier: _____ ID #: _____ Group #: _____

Subscriber's name: _____ Relationship to patient: _____ Member Services telephone: _____

Primary Care Physician: _____ Telephone: _____

Address: _____

Referring physician (if not PCP): _____ Telephone: _____

Address: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance carrier: _____ ID# _____ Group #: _____

Subscriber's name: _____ Relationship to patient: _____

RELEASE AND ASSIGNMENT FORM

To My Insurance Carriers:

1) I authorize the release of any medical information necessary to process my/my child's insurance claims.
2) I authorize and request payment of medical benefits directly to my/my child's physicians.
3) I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4) I agree that a photocopy of this form may be used in lieu of the original.
5) I understand that I am responsible for the charges that occur as result of my/my child's medical treatment.

_____ _____
Signature of patient/responsible party Date

MEDICARE LIFETIME AUTHORIZATION (Medicare Patients Only)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in lieu of the original and request payment of medical insurance benefits whether to myself or to the party who accepts this assignment. Regulations pertaining to Medicare assignments of benefits apply.

_____ _____
Signature of patient/responsible party Date