The Christ Hospital

THE CHRIST HOSPITAL PHYSICIAN DIVISION

Patient Registration Information R-7230 Rev. 12/11

Today's Date: _____

Patient Information: (please print)

Legal Name: _____ (Last) _____ (First) _____ (Middle Initial)

Social Security #: _____ Gender: M F Date of birth: _____

Maiden Name: _____ Other name(s) used/nicknames: _____

Address: _____ (Number Street) _____ (City) _____ (State) _____ (Zip)

Home #:( ) _____ Work #:( ) _____ Cell #:( ) _____

Email address: _____ Marital Status: S M D W Separated Partner

Language spoken (patient): _____ Language spoken (caregiver): _____

Need interpreter: Y N

Religion: _____ Ethnicity: Non-Hispanic Hispanic PCP: Dr. _____

Race: White African American American Indian Asian Native Alaskan Native Hawaiian Refused Other _____

Emergency Contacts: please enter two

Name: _____ Name: _____

Address/Zip: _____ Address/Zip: _____

Relation to patient: _____ Relation to patient: _____

Home #:( ) _____ Home #:( ) _____

Work #: ( ) _____ Work #: ( ) _____

Cell #: ( ) _____ Cell #: ( ) _____

Is there a: Legal Guardian: Y N Name: _____ POA: Y N Name: _____

Employment Information: Retired: Y N Date of retirement: _____

Patient's Employer: _____ Occupation: _____

Employer Address: _____ (Number Street City State Zip) Full time: _____ Part time: _____

Insurance Information:

Primary Ins Name/Claims Address:: _____

Policy/ID #: _____ Group #: _____ Pt. relationship to subscriber: Self Spouse Child Other

Subscriber Info: Name: _____ DOB: _____ SSN: _____

Employer: _____ Full time: ___ Part time: ___ Work #: _____

Address: _____ (Number Street City State Zip)

Secondary Ins. Name/Claims Address:: _____

Policy/ID #: _____ Group #: _____ Pt. relationship to subscriber: Self Spouse Child Other

Subscriber Info: Name: _____ DOB: _____ SSN: _____

Employer: _____ Full time: ___ Part time: ___ Work#: _____

Address: _____ (Number Street City State Zip)

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The Christ Hospital
ORTHOPAEDIC ASSOCIATES

Name: _____ Sex: _____ Age: _____ Today's Date: _____

Height: ___ft.___in. Weight: _____lbs. Recent Weight Change? ( ) gain ( ) loss ( ) none Are you? ( ) right-handed ( ) left-handed

WHAT PROBLEM ARE YOU BEING TREATED FOR TODAY? _____

Have you been treated by another physician for this problem? ( ) Yes ( ) No

Who? _____

Were x-rays taken? ( ) Yes ( ) No Where were they taken? _____ When? _____

Were other tests done? ( ) Yes ( ) No If yes, what were they, where and when were they performed?

_____

Pharmacy Name _____

Pharmacy Address _____ Pharmacy Phone _____

Allergy

Your Allergis to Medications (name medication and reaction. If none, state none) _____

Meds

Your Current Medications (name of medication, dose and how often. If none, state none)

_____ _____

_____ _____

Do you take: Aspirin ( ) Yes ( ) No Coumadin ( ) Yes ( ) No Plavix ( ) Yes ( ) No

PSHx

Past Surgeries (list type and year performed. If none, state none)

_____ _____

_____ _____

PMHx

Medical Illnesses (check any illness that you currently have or have had in the past)

___arthritis	___asthma	___bleeding disorder	___blood clots
___cancer	___cataract	___chronic pain	___depression
___diabetes	___fibromyalgia	___GERD (reflux)	___glaucoma
___gout	___heart disease	___viral hepatitus	___hypertension
___bladder/kidney infection	___neuropathy	___rheumatoid arthritis	___seizures
___stroke	___thyroid disorder	___GI ulcer	___vascular disease

___other _____

FMHx

Mother: ( ) living ( ) deceased Age (now or at death)_____ Cause of death _____

Father: ( ) living ( ) deceased Age (now or at death)_____ Cause of death _____

Genetic

Has any blood relative had any of the following (please check and indicate relationship, i.e. mother, father, sister, brother, etc.)

___anesthesia problem	___cancer	___kidney disease	___other
___arthritis	___diabetes	___seizures	_____
___asthma	___heart disease	___stroke	_____
___bleeding disorder	___high blood pressure	___tuberculosis	_____

SHx

( ) single ( ) married ( ) widowed ( ) separated ( ) divorced #of children____ and their present health status:_____

Your present occupation / job _____

Do you drink alcohol? ( ) Yes ( ) No Do you smoke? ( ) Yes ( ) No Packs per day _____ # of years _____

Do you use recreational drugs? ( ) Yes ( ) No

Signature: Patient's _____ **Today's Date:** _____ Dr's Initials: _____ Date: _____

C1800