ASANTE
Physician Partners

Orthopedic Surgery
537 SW Union Ave
Grants Pass, OR 97527
Phone: 541-507-2050

It is very important that you arrive for this appointment no later than 20 minutes prior to the time of your appointment. In the event you arrive late, we may not be able to see you on time. Or, in some cases, it may be necessary to reschedule your appointment.

Enclosed please find a registration form and medical questionnaire. We ask that you carefully complete these forms and mail them to our office in the enclosed envelope. Please do this as soon as possible in order to allow us to prepare for your visit. However, if you are not able to mail the forms within 3 days prior to your appointment date, please bring them with you to your appointment instead of mailing.

In order to allow us to provide you with the best possible care, please bring the following with you to your visit:

- A list of all of your current medications
- Your completed medical questionnaire (if you have not already mailed it to us)
- Your insurance card

If you must cancel your appointment, we require at least 24-hour notice for appointments and a 72-hour notice for surgical procedures.

Your first appointment with us will be for a consultation. Please understand this visit is required prior to any surgical procedure. Also, if your insurance company requires a referral or authorization for specialty care appointments, it is your responsibility to ensure the insurance company has obtained this information. Amounts not covered by your insurance are due at the time of service.

We look forward to seeing you soon.

Sincerely,

The staff of Asante Physician Partners Orthopedic Surgery

PLEASE PRINT **REGISTRATION FORM** **COMPLETE ALL BOXES**

Patient Information

Name:_____ SSN: _____ Gender: M F
Date of Birth: _____ Previous Name:_____
City of Birth _____ Country of Origin _____
Street Address: _____**P.O. Box**_____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone_____
Language: _____Need Interpreter: ☐Yes ☐No Marital Status: _____ Religion: _____
Race: _____ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐No Response
Primary Care Provider/Family Doctor: _____ Email Address: _____
Is legal counsel involved in your care? ☐Yes ☐No

☐ Same as Patient

Responsible Party

Responsible Party: _____ SSN: _____
Address: _____Phone: _____Relationship to Patient: _____
Employer:_____ Work Address: _____Work Phone:_____

Patient Contacts

Name: _____ Relationship to Patient: _____Phone: _____
Address: _____
Name: _____ Relationship to Patient: _____Phone: _____
(Not Living with Patient)

Employer Information

Patient Employer: _____ Employer Address:_____
Employment Status: ☐Full Time ☐Part Time ☐Student Employer Phone:_____

Health Insurance Information

Primary Insurance: _____ Member ID: _____ Group #: _____

Effective Date:_____ Subscriber Name: _____ SSN: _____
DOB: _____ Subscriber Address: _____ Subscriber's Employer:_____ Number of Employees: ☐ 1-19 ☐ 20-99 ☐ 100+ Phone: _____Relation to Patient:_____
Secondary Insurance:_____(If applicable) Member ID: _____Group #: _____
Effective Date:_____ Subscriber Name: _____ SSN: _____
DOB: _____ Subscriber Address: _____ Subscriber's Employer:_____
Number of Employees: ☐ 1-19 ☐ 20-99 ☐ 100+ Phone: _____ Relation to Patient:_____

For Work Related Injuries

Date of Injury: _____ Injury/Accident Insurance Carrier: _____ Claim/Auth #:_____

How did you hear about our clinic?

☐Referral from your primary care physician ☐ Word of Mouth ☐ Postcard mailed to your home
☐ Website ☐Newspaper Article ☐Newspaper Advertisement ☐ Radio Advertisement ☐Yellow Pages
May we contact you via email regarding special promotions or to request information about our services? ☐ Yes ☐ No

Date: _____

APP Orthopedic Surgery
537 SW Union Ave
Grants Pass, OR 97527
Phone: 541-507-2050 Fax: 541-474-5009

PATIENT: _____ DOB: ____/____/____

ALLERGIES	*Reaction*
Aspirin	_____
Codeine	_____
Morphine	_____
Other Allergies	_____

CURRENT MEDICATIONS

(Including vitamins, herbs, diet pills, OTC, etc.)

Drug Name	Strength	Dosage

PAST MEDICAL HISTORY – Please check if you have experienced any of the following problems:

- ☐ Alcoholism_____
- ☐ Anemia _____
- ☐ Arthritis _____
- ☐ Anxiety _____
- ☐ Arrhythmia _____
- ☐ Asthma _____
- ☐ Blood Dyscrasia _____
- ☐ Blood Transfusion _____
- ☐ Bronchitis _____
- ☐ Cancer _____
- ☐ CHF _____
- ☐ Clotting disorder _____
- ☐ Concussion _____
- ☐ COPD _____
- ☐ Chronic Lung Disease _____
- ☐ Diabetes mellitus _____
- ☐ Dermatitis _____
- ☐ Emphysema _____
- ☐ GERD _____
- ☐ Glaucoma _____
- ☐ Heart Disease _____
- ☐ Heart Murmur _____
- ☐ Hepatitis _____
- ☐ Herpes _____
- ☐ HIV/AIDS _____
- ☐ Hypertension _____
- ☐ Inflammatory bowel disease
- ☐ Jaundice _____
- ☐ Kidney Disease _____
- ☐ Kidney Stones _____
- ☐ Leukemia _____
- ☐ Liver Disease _____
- ☐ Meningitis _____
- ☐ Myocardial infarction_____
- ☐ Nerve/muscle disease_____
- ☐ Osteoporosis _____
- ☐ Pneumonia _____
- ☐ Psychiatric Problem _____
- ☐ Rheumatic Fever_____
- ☐ Seizures _____
- ☐ Sickle cell anemia _____
- ☐ STD _____
- ☐ Thyroid disease _____
- ☐ Tuberculosis _____
- ☐ Ulcers _____
- ☐ Varicosities/Phlebitis _____

☐ Other Serious Illnesses or Injuries:_____

SURGERIES/HOSPITALIZATIONS – Please check if you have had surgery or hospitalization for the following:

	Year		Year		Year
☐ Adenoidectomy	_____	☐ Cyst Removal	_____	☐ Ovary removal	_____
☐ Ankle Arthroscopy	_____	☐ Dilate and curettage	_____	☐ Peripheral Artery Bypass Graft	_____
☐ Aortic Valve Replacement	_____	☐ Elbow Arthroscopy	_____	☐ Prostate surgery	_____
☐ Appendectomy	_____	☐ Exploratory Laparotomy/Laparoscopy	_____	☐ Shoulder Arthroscopy	_____
☐ Back surgery	_____	☐ Eye surgery	_____	☐ Small intestine surgery	_____
☐ Biopsy	_____	☐ Fracture surgery	_____	☐ Spine surgery	_____
☐ Brain surgery	_____	☐ Heart surgery	_____	☐ Splenectomy	_____
☐ CABG	_____	☐ Hernia repair	_____	☐ Thumb Arthroscopy	_____
☐ Carotid endarterectomy	_____	☐ Hip surgery	_____	☐ Thyroid surgery	_____
☐ Carpal tunnel release	_____	☐ Hysterectomy	_____	☐ Tonsillectomy	_____
☐ Cataract removal/IOL implant	_____	☐ Incision and drainage	_____	☐ Tubal ligation	_____
☐ Cholecystectomy	_____	☐ Joint replacement	_____	☐ TURP	_____
☐ Colon surgery	_____	☐ Knee surgery	_____	☐ Upper GI endoscopy	_____
☐ Colonoscopy	_____	☐ Lower Endoscopy	_____	☐ Valve replacement	_____
☐ Coronary angioplasty	_____	☐ Lumpectomy	_____	☐ Vasectomy	_____
☐ Cosmetic surgery	_____	☐ Mastectomy	_____	☐ Wrist Arthroscopy	_____
☐ C-Section	_____				

PATIENT : _____ **DOB:** ____/____/____ **DATE:**_____

FAMILY HISTORY – Please check if your family members (parents, siblings, children, aunts, uncles) have had any of the following:

	Diagnosis	Relationship(s)	Living		Diagnosis	Relationship(s)	Living
☐	Alcohol Abuse		Y/N	☐	Heart Disease		Y/N
☐	Arthritis		Y/N	☐	High cholesterol		Y/N
☐	Asthma		Y/N	☐	Hypertension		Y/N
☐	Birth Defect		Y/N	☐	Kidney Disease		Y/N
☐	Cancer		Y/N	☐	Learning Disability		Y/N
☐	COPD		Y/N	☐	Mental Illness		Y/N
☐	Depression		Y/N	☐	Mental Retardation		Y/N
☐	Diabetes		Y/N	☐	Miscarriage/Stillbirth		Y/N
☐	Drug Abuse		Y/N	☐	Stroke		Y/N
☐	Early Death		Y/N	☐	Vision Loss		Y/N
☐	Hearing Loss		Y/N		Other:		Y/N
☐	Other:						Y/N

SOCIAL HISTORY

Alcohol Use: ☐ YES ☐ NO

per week: _____ glasses of wine _____ cans of beer _____ Other drinks containing 0.5 oz of alcohol

Sexually Active? ☐ YES ☐ NO Partners: ☐ FEMALE ☐ MALE

Birth Control/Protection (if using, please describe): _____

Drug Use – ☐ YES ☐ NO Type: Use/week:

Tobacco Use – Do you smoke now ☐ YES ☐ NO

If yes, are you ready to quit? ☐ YES ☐ NO If no, have you ever smoked? ☐ YES ☐ NO

Years of use: _____ Yrs Year quit _____

Other Tobacco Products Used: _____

Do you consume caffeine? ☐ YES ☐ NO

Do you exercise? ☐ YES ☐ NO What type? _____ How often?_____ Times/week

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Spouse Name: _____ Number of Children _____ Yrs of Education _____

Occupation: _____

HEALTH MAINTENANCE

Colonoscopy:	☐ YES ☐ NO Year: _____	Influenza Immunization:	☐ YES ☐ NO Year: _____
Dexa (Bone) Scan	☐ YES ☐ NO Year: _____	Pneumonia Vaccine:	☐ YES ☐ NO Year: _____
PSA Screening:	☐ YES ☐ NO Year: _____	Tetanus Vaccine:	☐ YES ☐ NO Year: _____
Mammography:	☐ YES ☐ NO Year: _____		

WOMAN'S HEALTH

		Pregnancies	Total	Pregnancies	Total
Age Periods Started	_____	Full-Term	_____	# of Children Living	_____
Age at 1st Birth	_____	Pre-Term (37 wks)	_____	Ectopic or Tubal	_____
Age/Year Menopause	_____	Miscarriages	_____	Live Births Cesarean	_____
Last Pap Smear	_____	Elective Abortions	_____	Live Births Vaginal	_____

PATIENT : _____ **DOB:** ____/____/____ **DATE:**_____

Please mark any of the following that you are **currently** experiencing

Constitutional:
☐Fever
☐Chills
☐Weight loss
☐Malaise/Fatigue
☐Diaphoresis
☐Weakness

Skin:
☐Rash
☐Itching

HENT:
☐Headaches
☐Hearing loss
☐Tinnitus
☐Ear pain
☐Ear discharge
☐Nosebleeds
☐Congestion
☐Stridor
☐Sore throat

Eyes:
☐Blurred vision
☐Double vision
☐Photophobia
☐Eye pain
☐Eye discharge
☐Eye redness

Cardiovascular:
☐Chest pain
☐Palpitations
☐Orthopnea
☐Claudication
☐Leg swelling
☐PND

Respiratory:
☐Cough
☐Hemoptysis
☐Sputum production
☐Shortness of breath
☐Wheezing

Gastrointestinal:
☐Heartburn
☐Nausea
☐Vomiting
☐Abdominal pain
☐Diarrhea
☐Constipation
☐Blood in stool
☐Melena

Gentourinary:
☐Dysuria
☐Urgency
☐Frequency
☐Hematuria
☐Flank pain

Musculoskeletal:
☐Myalgias
☐Neck pain
☐Back pain
☐Joint pain
☐Falls

Endo/Heme/Aller:
☐Easy bruise/bleed
☐Env allergies
☐Polydipsia

Neurological:
☐Dizziness
☐Tingling
☐Tremor
☐Sensory change
☐Speech change
☐Focal weakness
☐Seizures
☐LOC

Psychiatric
☐Depression
☐Suicidal ideas
☐Substance abuse
☐Hallucinations
☐Nervous/Anxious
☐Insomnia
☐Memory loss

☐ Breast pain/tenderness
☐ Breat discharge
  ☐-Bloody discharge
☐ Breast lump
☐ Breast ulcer/wound