H. Relton McCarroll, Jr, MD *Hand, Wrist and Elbow Surgery*
Tom R. Norris, MD, PC *Shoulder and Elbow Surgery*
James D. Kelly, II, MD *Shoulder and Elbow Surgery*
Hillary G. Redlin, MD *Hand, Wrist and Elbow Surgery*
Mark A. Schrumpf, MD *Shoulder and Elbow Surgery*

Patient Registration

Name: (Last) ________________ (First) ________________ (M.I.) ____ Gender: M/F/O DOB:________ AGE:_______

Address: (Street) ______________________________ (City) ___________________ (State) _______ (Zip) ___________

Phone: M/H/W/O _____________________________ Alt. Phone: M/H/W/O ___________________________________

Email Address: ______________________________ SS#__________________________ Marital Status: S/M/D/W/O

Preferred Language: ____ Ethnicity: ( )Hispanic ( )Non-hispanic ( ) Unknown

Race: ( )American Indian/Alaska Native ( )Asian ( )Black/African American ( )Pacific Islander ( )White ( )Other ( )Decline

Emergency Contact: (Name) _______________________ (Phone) ___________________ (Relationship) ______________

Occupation: _____________________________________ Employer: ____

Primary Care Physician:

(Name) ________________________________ (Phone) _________________________ (Fax) ____________________________

(Address) _______________________________ (city) _______________________ (state) __________ (zip) ________________

Referring Physician:

(Name) ________________________________ (Phone) _________________________ (Fax) ____________________________

(Address) ________________________________ (city) _______________________ (state) __________ (zip) ________________

Reason For Visit:

Area to be examined: RT/LT __________________ How Injured: ____

DOI (if applicable) _________________________ Work Related? Y/N Dominant Hand: LT/RT

X-rays taken? Y/N When: ___________________ Where: ____

Have you had surgery on this body part? ____

Insurance Information:

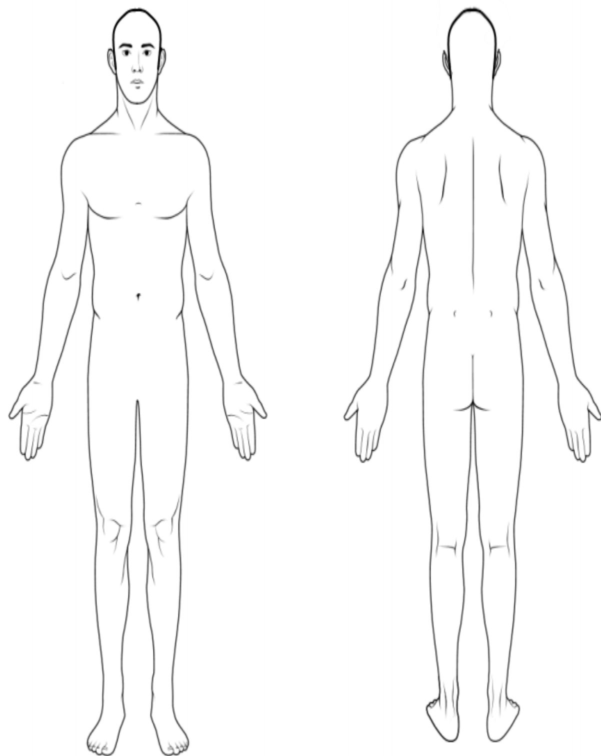
Primary Insurance: ___________________________________ Secondary Insurance: ______________________________

Name of insured: ____________________________________ DOB: __________ SS # _________________________________

Name ______________________________

Medical History

Please mark the areas where you feel pain in the diagram below:



Circle the number that describes the severity of your pain:

no pain 1 2 3 4 5 6 7 8 9 10 severe pain

Review of Systems:
Please check any that apply to you at this time.

Constitutional
( ) fevers/chills/sweats
( ) unexplained weight gain/loss
( ) excessive thirst/urination

Cardiovascular
( ) chest pain
( ) palpitations

Respiratory
( ) coughing/wheezing
( ) shortness of breath

Gastrointestinal
( ) blood in bowels
( ) abdominal pain
( ) nausea/vomiting
( ) diarrhea

Neurological
( ) dizziness/light headedness
( ) numbness
( ) loss of coordination

Psychiatric
( ) anxiety/stress
( ) trouble sleeping
( ) depression

Other
( ) easy bruising
( ) Rash

Height: _____ ft _____ in **Weight:** _________ lbs

Are you being treated for any of the following medical conditions?

( ) High blood pressure	( ) Heart	( ) Sleep Apnea
( ) Diabetes	( ) Lungs	( ) Pulmonary Embolism
( ) Kidney Disease	( ) Ulcers	( ) Other-Please Explain:______________

Have you ever had a heart condition or heart surgery? ______________________________

Do you have a pacemaker or defibrillator? ______________________________

Are you a smoker? ______________ packs per day?______________

Do you have any history of bleeding disorders? (please describe) ______________________________

Are there any rare or unusual diseases in your family? ______________________________

Are you currently taking any medications ? (List here or attach) ______________________________

____

Do you have any allergies to medications? ______________________________

Please list any surgeries you have had in the last 10 years with approximate dates: ______________

____

Have you ever had any orthopaedic injuries or conditions including fractures or dislocations? (please describe)

____

HIPPA & Authorization to Release Information and Insurance Benefits

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment, or health operations, in order to provide health care that is in your best interest. We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not the patient), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your personal health information. If you choose to give consent in this document at some future time you may request to refuse all or part of your personal health information. You may not revoke actions which have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

FOR OFFICE USE ONLY

In signing below, I acknowledge that I have read or received a copy of our Privacy Practices and consent to use and disclosure of protected health information about my treatment, payment and health care operations.

I authorize the San Francisco Shoulder, Elbow and Hand Clinic to give me reasonable and proper medical care by today's standards.

I have provided the San Francisco Shoulder, Elbow and Hand Clinic with my most current insurance information and copies of insurance cards if applicable.

Signature ____________________ **Date** ____________

Industrial Injuries ONLY

Date of Injury: ______________ Claim #: ______________________

Worker's Compensation Insurance Carrier: ______________________

Carrier Address: (street) ____________ (city) __________(state) ______ (zip) ________

Claims Adjuster: ______________ (Phone) __________ (Fax) ____________

Attorney: ______________ (Phone) __________ (Fax) ____________

Employer: ______________________________

Are you currently working? (please indicate part time/full time/light duty)____________________

Do you have a primary treating physician for this case? ____________________

Is there anything else we should know about your claim? ____________________