Adventist Health Physician's Network
Glendale Orthopaedics
Ryan Morgan, M.D.

## Patient Registration

Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Height: _____ Weight: _____ Gender: Male | Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile: _____ Work: _____

o Check here if you do not wish for us to leave a full message at the above listed phone numbers.

E-mail: _____

We will be sending a link to access your medical records online. Your Zip Code will be your passcode.

Race: _____ Marital Status: _____

Social Security #: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Physician: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Cardiologist: _____ Phone: _____

## Individual Patients Authorization

Please **list below** the names of individuals (ex. Family members or significant others) who you give permission to have access to your medical information within our office. Without your consent we will not share any information including appointments with any individuals not part of your care. If you do not wish to give anyone permission, write none.

_____ _____ _____

**Acknowledgement of Receipt of Notice of Privacy Practices**

Use & disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability & Accountability Act of 1996 **("HIPAA")**. Under **HIPAA**, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information & make good faith effort to obtain a written acknowledgement that this notice was received.

Therefore I,_____(printed name of patient or personal representative), acknowledge that AHPN Glendale Orthopaedics has provided a written copy of its Notice of Privacy Practices for Protected Health Information to myself.

**CONSENT FOR EXAMINATION AND TREATMENT, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

- ✓ I hereby consent to and authorize any counseling, examination, or treatment which may be necessary.
- ✓ I hereby consent to and authorize any additional testing that may be indicated.
- ✓ I hereby authorize APHN Glendale Orthopaedics to release the information requested by any insurance plan or other agency sponsoring my health care bills.
- ✓ I directly assign all medical and surgical benefits to AHPN Glendale Orthopaedics.
- ✓ I hereby authorize AHPN Glendale Orthopaedics to release all information necessary to secure the payment benefits.
- ✓ I understand that I am financially responsible for all charges paid by my insurance or not.
- ✓ I further agree that a photocopy of this agreement shall be as valid as the original

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

*****(If signing as a personal representative, documentation of your legal rights to do so must be provided) *****

_____ _____

Signature of Patient Date

***To be completed by: AHPN Glendale Orthopaedics Staff***

*We made a good faith attempt to provide the above-named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reasons:*

_____

_____

**Pharmacy:**_____ **Phone**: _____

## Medical History

Reason for your visit today:

_____

What form of treatment have you received for this condition?
(X-rays, MRI's, Injections, Physical Therapy)

_____

_____

List any medical conditions you have:

□ Diabetes □ Cholesterol □ High Blood Pressure □ Other: _____

List all past surgeries including dates:

_____

**Do you have any allergies to medication? Yes | No**

If yes, what medications are you allergic to?

_____ _____

List all medications and dosage you are taking:

_____ _____

_____ _____

_____ _____

Please list any family medical history we should be aware of:

_____

Do you drink alcohol? Yes | No Amount weekly? _____

Do you smoke? Yes | No Amount daily? _____

Ex-Smoker:_____months / years

Have you/or are using illicit drugs? Yes | No

If yes, please specify:_____

Are you, regularly, able to complete your own daily activities such as dressing self, driving, walking to buy groceries? YES | NO

IF NO, then please complete the following section:

□ Do you live alone? YES NO

□ Do you have a regular caretaker? YES NO

□ How many stories in your home? _____

□ How many stairs in your home? _____

□ Is there a (circle all that applies)

Elevator | Ramp | Wheelchair Access

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□ Do you use assistive devices (circle all that applies)

Walker | Cane | Crutches | Wheelchair | Power Wheelchair

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□ Can you bathe and clothe yourself? YES NO

□ Do you drive? YES NO

□ List the daily activities you have difficulty with:

_____

I hereby certify to the best of my knowledge, all of the answers on this patient registration and history form is complete and correct.

_____ _____

**Patient Signature** **Date**