

Allegheny Orthopaedic Associates • Patient Registration (Please Print)

Last Name		First Name		M.I.
Street Address		City, State		Zip Code
Social Security #: _____ - _____ - _____		Date of Birth: ____/____/____		Marital Status: M S D W Other
Phone Numbers: home (____) _____ - _____ cell (____) _____ - _____ work (____) _____ - _____				
Employer	Occupation	Employer Street Address	City, State	Zip Code
In Case of Emergency Notify		Phone Number: (____) _____ - _____		Relationship
Nearest Relative Not Living with You		Phone Number: (____) _____ - _____		Relationship
Referring Physician: Phone Number: (____) _____ - _____		Primary Physician: Phone Number: (____) _____ - _____		
Insurance Information				
Primary Insurance Company Name		Secondary Insurance Company Name		
I.D. #	Group #	I.D. #	Group #	
Copay: \$ /Specialist: \$	Effective Date	Copay: \$ /Specialist: \$	Effective Date	
Insurance Address		Insurance Address		
Subscriber's Name	Relationship	Subscriber's Name	Relationship	
Subscriber's SS#	Birthdate	Subscriber's SS#	Birthdate	
Subscriber's Address		Subscriber's Address		
Subscriber's Phone Number: (____) _____ - _____		Subscriber's Phone Number: (____) _____ - _____		
Employer's Name: Phone Number: (____) _____ - _____		Employer's Name: Phone Number: (____) _____ - _____		
Accident Information				
Date of Accident		Insurance Company to be Billed		
Billing Street Address		City, State		Zip Code
Claim Type: Worker's Comp. Auto Other	Claim #	Phone Number: (____) _____ - _____		
Contact Person	Description of Injury			

Date Completed: _____

JOHN J. CHRISTOFORETTI, M.D.

New Patient / New Problem Questionnaire

NAME: _____ AGE: _____ DATE: _____

REF. MD: _____ PCP: _____

OCCUPATION: _____ STATUS WORKING: F.T. P.T. LOA

CHIEF COMPLAINT:

SHOULDER: R L B/L

HIP: R L B/L

KNEE: R L B/L

OTHER _____: R L B/L

DURATION OF PROBLEM: _____ PAIN LEVEL (0-10): _____

TYPE OF PAIN (dull sharp burning etc.): _____

RADIATE Y N WHERE: _____

AGGRAVATING FACTORS: _____

ALLEVIATING FACTORS: _____

PAIN: NIGHT ACTIVITY REST

PRIOR MD TREATMENT: Y N _____

PREVIOUS TREATMENT:

PRIOR DIAGNOSTICS:

BRACE
HEAT / ICE / REST
COMPRESSION
ELEVATION
CHIROPRACTOR
PHYSICAL THERAPY
INJECTION(S):

XR:

MRI:

CT:

EMG / NCV:

BONE SCAN:

OTHER: _____

ALLERGIES: _____

MEDICATIONS: _____

MEDICAL PROBLEMS: _____

SURGICAL HX: _____

SMOKING: Y N
PPD / YEARS: _____

EXERCISE: Y N
TIMES PER WEEK: _____

MEDICATIONS:

ALLEGHENY ORTHOPAEDIC ASSOCIATES

Authorization for Release of Protected Health Information

Patient Name: _____
Last Initial First

Date of Birth (XX/XX/XXX): _____ Last Four (4) Digits of Patient's SSN: _____

Address: _____

Phone Number: _____ Fax Number: _____

I hereby authorize the following person(s) or entity to release my Protected Health Information (PHI):

Name of Provider: _____
Street Address: _____
City, State Zip Code: _____
Phone and Fax: _____

Please choose who will receive the information and the method of delivery. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

- To me. Please deliver by U.S. Mail to my personal address. (Records will be mailed to address listed above)
- To me. I prefer to pick up my records personally. Please call me when they are ready. (Photo ID will be required for pick up)
- To the following person or entity:

Name of individual, medical office, company/entity you want to receive the records

Street Address

City State Zip Code

Phone Number Fax Number

The Protected Health Information (PHI) or copies of I would like to have released is as follows:

- Release my entire chart (I understand that information may include acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus; mental health care; treatment for alcohol and/or drug abuse; and sexually transmitted disease unless otherwise indicated.)

Do not release: AIDS/HIV Mental Health (Psychiatric) Drug & Alcohol

- Other (specifically identify exact information to be disclosed, including specific dates of service):

The purpose of my request is:

Continuing Treatment

Legal

Employer

Personal Use

Insurance

Study/Research

Other: _____

I understand that this authorization shall expire one (1) year from the date of signature unless otherwise specified below. Expiration date may not exceed one year from the date of signature. If applicable, specify other expiration date/event here: _____

I understand that I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.

I understand that I am not required to sign this Authorization as condition of my obtaining treatment.

I understand that, to the extent that any Recipient of this information, as identified above, is not a "covered entity" under Federal Law, the information may no longer be protected by federal and state law. I understand that, in these circumstances, the individual receiving this information may be permitted to re-disclose the information. I understand that my healthcare provider is not responsible should the individual receiving this information re-disclose the information.

I am entitled to a copy of this completed Authorization upon my request.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Signature of Patient _____

Date _____

Signature of Parent, Legal Guardian or Authorized Representative* _____

Date _____

Witness/Staff Member Signature _____

Date _____

If signed by an Authorized Representative, complete the following:

Printed Name of Personal Representative: _____

Description of Authority to Act for Individual: _____

(If you have not already provided us with the appropriate legal documents supporting your personal representative status, please submit these documents with the form.)

ORAL AUTHORIZATION

Only to be used if the patient is physically unable to sign. This is NOT applicable to HIV related information or Drug & Alcohol Treatment.

I witness that the nature of this release has been explained to the patient, that the patient understood the nature of the release and freely gave oral authorization. (Two witnesses are required)

Witness: _____

Date: _____

Witness: _____

Date: _____