

\*Have you been vaccinated for COVID: Y / N

\*Have you ever tested positive for COVID: Y / N

# ORTHOPAEDIC SURGICAL ASSOCIATES

## Patient Registration Form

### PATIENT INFORMATION

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Gender: M / F SS#: \_\_\_\_\_ Marital Status: Married / Single / Divorced / Widow / Separated

Are you on Disability? Y / N If yes, why? \_\_\_\_\_

Occupation: \_\_\_\_\_ Ethnicity: **White / African American / Hispanic / Asian / Other:** \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Is patient a resident at a long-term care facility? Y / N If yes, Facility Name: \_\_\_\_\_

### INSURANCE INFORMATION (Please present your insurance card for photocopying)

**PRIMARY INSURANCE:** \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Place of Employment: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Subscriber Place of Employment: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**DATE OF INJURY:** \_\_\_\_\_

Reason for visit: \_\_\_\_\_ **Left / Right / Both** Hand Dominance: **Right / Left**

How long have your symptoms been present? \_\_\_\_\_

Brief description of how injury occurred: \_\_\_\_\_

Is injury work related? Y / N Currently working / employed? Y / N Auto Accident? Y / N Lawsuit Pending? Y / N

**If the injury is not work or auto related, please sign the following statement:**

**I certify that this injury is not related to work or an auto accident:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICAL INFORMATION:**

**Present Medications:** Pharmacy's Name, Address & Phone Number: \_\_\_\_\_

- |                |                |
|----------------|----------------|
| 1. Name: _____ | 4. Name: _____ |
| 2. Name: _____ | 5. Name: _____ |
| 3. Name: _____ | 6. Name: _____ |

**Allergies to Medications (Please list Medications and Reactions) :**

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Do you have any allergies to metals? Y / N

**Height :** \_\_\_\_\_ ft. \_\_\_\_\_ in. **Weight:** \_\_\_\_\_ lbs. (MANDATORY)

**REVIEW OF SYMPTOMS: (Please check all that apply)**

Is your Primary Care Physician aware of the symptoms below? Y / N

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Fever                           | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent Urination           |
| <input type="checkbox"/> Night Sweats                    | <input type="checkbox"/> Nausea or Vomiting  | <input type="checkbox"/> Rash                         |
| <input type="checkbox"/> Recent Weight Gain (_____ lbs.) | <input type="checkbox"/> Poor Appetite       | <input type="checkbox"/> Recent Loss of Consciousness |
| <input type="checkbox"/> Recent Weight Loss (_____ lbs.) | <input type="checkbox"/> Frequent Diarrhea   | <input type="checkbox"/> Alcohol Abuse                |
| <input type="checkbox"/> Difficulty Hearing              | <input type="checkbox"/> Black Stool         | <input type="checkbox"/> Excessive Bleeding           |
| <input type="checkbox"/> Heart or Chest Pain             |  |   |

**EXISTING / PAST MEDICAL HISTORY: (Please check all that apply)**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Depression                        | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Anxiety Disorder        | <input type="checkbox"/> Diabetes (Insulin or Non-Insulin) | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Pulmonary Embolism          |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> GERD / Reflux                     | <input type="checkbox"/> Leg or Foot Ulcers | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Gout                              | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Seizures / Epilepsy         |
| <input type="checkbox"/> Bleeding Disorder       | <input type="checkbox"/> Heart Attack (MI)                 | <input type="checkbox"/> Lung Disease       | <input type="checkbox"/> Sleep Apnea                 |
| <input type="checkbox"/> Blood Clots             | <input type="checkbox"/> Heart Disease                     | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Cancer: Type: _____     | <input type="checkbox"/> Hepatitis                         | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Thyroid Problems            |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> HIV or AIDS                       | <input type="checkbox"/> Pace Maker         | <input type="checkbox"/> Tuberculosis                |
|  |  |   | <input type="checkbox"/> Ulcers                      |

Y / N Other Medical Problems: \_\_\_\_\_

**PREVIOUS SURGERIES: (please check all that apply & include dates)**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AAA Repair _____                                | <input type="checkbox"/> Chest Surgery _____         | <input type="checkbox"/> Neck Surgery _____        | <input type="checkbox"/> Plastic Surgery _____    |
| <input type="checkbox"/> Abdominal Surgery _____                         | <input type="checkbox"/> Heart Stent Placement _____ | <input type="checkbox"/> Brain Surgery _____       | <input type="checkbox"/> Lower Back Surgery _____ |
| <input type="checkbox"/> Cancer Surgery _____                            | <input type="checkbox"/> Heart Surgery _____         | <input type="checkbox"/> Orthopaedic Surgery _____ | <input type="checkbox"/> Thyroid Surgery _____    |
| <input type="checkbox"/> Cardiac Catheterization _____                   | <input type="checkbox"/> Leg Amputation _____        | <input type="checkbox"/> Pace Maker _____          | <input type="checkbox"/> Vascular Surgery _____   |
| <input type="checkbox"/> Please list specific surgeries and dates: _____ |  |  |   |

**EXISTING FAMILY HISTORY: (Please check all that apply)**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Osteoarthritis       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Rheumatoid Arthritis |

**SOCIAL HISTORY:**

Do you smoke? Y / N If yes, how many packs/day? \_\_\_\_\_ How many years? \_\_\_\_\_

E-Cigarettes: Y / N

Smokeless Tobacco: Y / N  Chewing Tobacco  Moist Powdered Tobacco

Do you drink alcohol? Y / N If yes, how often? \_\_\_\_\_ How many years? \_\_\_\_\_

History of Intravenous Drug Use? Y / N



Telephone: (978) 654-5050

**Orthopaedic  
Surgical  
Associates**

**Authorization to pay benefits to Orthopaedic Surgical Associates:**

**Telephone: (978) 454-0706**

Samuel D. Gerber, MD  
F.A.C.S.  
Sports Medicine  
Knee and Shoulder Surgery  
Arthroscopic Surgery

Eric D. Holstein, MD  
General Orthopaedics  
Sports Medicine  
Fracture Care

Scott A. Sigman, MD  
Sports Medicine  
Knee and Shoulder Surgery  
Arthroscopic Surgery

Steven Alter, MD  
Hand and Upper Extremity Surgery  
Trauma Surgery

Mark A. Lapp, MD  
Spinal Surgery  
Asst. Professor of Orthopaedics  
Tufts University School of Medicine

W. Howard Wu, MD  
Sports Medicine  
Arthroscopic Surgery  
Joint Reconstruction

Atul L. Bhat, MD  
Interventional Physiatry  
Spinal Disorders

Jeremy M. Moses, MD  
Sports Medicine  
Knee and Shoulder Surgery  
Arthroscopic Surgery

David J. Prybyla, MD  
Joint Reconstruction  
Fracture Care

Christopher W. Baker, MD  
Foot and Ankle Surgery  
Trauma Surgery

Elizabeth Geants, MD  
Hand Surgery  
Fracture Care

Matthew J. Sabatino MD  
Reconstructive Spine Surgery  
Scoliosis & Spine Deformity  
Minimally Invasive Spine Surgery

Steven T. DiSenga, MD  
Orthopaedic Surgery  
Joint Reconstruction

Jessica Carey, NP-C  
Roula Johnstone, NP-C  
Kristen Proverb, NP-C  
June Stott, NP-C  
Allison Devine, PA-C  
Stacey Murphy, FNP-C

I hereby authorize my insurance company and/or companies to pay directly to Orthopaedic Surgical Associates any proceeds payable under the terms of my policy and/or policies is my obligation and will be paid by me. I hereby authorize Orthopaedic Surgical Associates to release any information necessary to process this claim. **Effective March 1, 2013**, for any account sent to Collections, the patient /or guarantor will be liable to any fees associated with the collection process.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA REGULATIONS: (ON LEDGE OF CHECK IN WINDOW)**

I acknowledge having received a copy of the organization's Notice of Privacy Practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

As an HMO member, I understand that I have an obligation to obtain a referral from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have a referral for today's appointment that I will be responsible for payment of services should they be denied by my HMO plan.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Team Physicians - UMASS Lowell**

**14 Research Place. North Chelmsford. MA 01863 | Fax: (978) 970-0454**

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Surgical  
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*Sports Medicine  
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Sports Medicine  
Fracture Care**

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Trauma Surgery**

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Trauma Surgery**

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June Stott, NP-C  
Allison Devine, PA-C  
Stacey Murphy, RN-C**



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**Financial Policy**

It is the patient / parent / guardian's responsibility to:

- Be familiar with the benefits of your insurance plan including co-pays, co-insurance, and deductible and referral authorization requirements.
- Bring all insurance cards to all visits.
- Provide our office with current information including address, telephone numbers, driver's license or ID and name of your employer.
- Be prepared, in accordance with your insurance contract, to pay your co-payments at the time of your visit.
- Obtain a referral, if required in order for your visit to be covered by insurance. If you do not have a referral you may be asked to sign a waiver or have your appointment re-scheduled.
- Be prepared to pay a deposit prior to the date of any procedures that are scheduled for you if your insurance has a deductible. A \$300.00 deposit is required for elective surgeries. If you have met your yearly deductible the deposit may be waived. There will be an opportunity to provide payment by credit card, cash, or check. The amount charges will not exceed your deductible or the payment amount allowed by your insurance for the procedure you are having.
- Effective April 1, 2013, there will be a \$50.00 fee charged to patients who fail to give 24 hour notice for cancellation or re-scheduling of an appointment.

Please be advised that a diagnosis will not be modified to fit your plan benefits.

Our office participates in most major insurance plans. We accept cash, checks, and Mastercard or Visa.

\_\_\_\_\_  
Signature of patient / parent / guardian

\_\_\_\_\_  
Date

Printed Name of Patient

*Team Physicians - UMASS Lowell  
14 Research Place, North Chelmsford, MA 01863 | Fax: (978) 970-0454*

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# PATIENT AUTHORIZATION FORM

## Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Orthopaedics Surgical Associates to speak with and release any information requested to the following individuals.

1. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
2. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
3. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
4. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

## Authorization Regarding Messages/Records

\_\_\_\_\_ I authorize you to leave a detailed message on my home or cell number regarding appointments, medical treatment, care, test results or financial information

\_\_\_\_\_ I authorize \_\_\_\_\_ to pick up medical records, work notes, school notes, prescriptions.

Patient Name (PLEASE PRINT) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_