ORTHOPAEDIC ASSOCIATES OF MARLBOROUGH

65 Fremont Street | Marlborough, MA 01752 | 508.485.3665

PATIENT REGISTRATION FORM

PLACE CHECK NEXT TO DOCTOR YOU ARE SEEING

☐ Donald Hangen, M.D. ☐ Paul Pongor, M.D. ☐ Stephen A. Klinge, M.D.
☐ Markian Stecyk, M.D. ☐ Steven Sewall, M.D. ☐ Wendy Leontie, PA-C

PERSONAL INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: _____ ☐ Male ☐ Female

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Employer Name: _____ Work Phone: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

IF UNDER 18, PERSON(S) LEGALLY RESPONSIBLE FOR PATIENT

Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

INJURY INFORMATION

Date of Injury: _____

Is this injury the Result of: ☐ Auto Accident ☐ Work Injury ☐ Other Accident/Injury: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ ID or Member #: _____

Subscriber Name: _____ Group or Policy Number: _____

Subscriber DOB: _____ Relation to Patient: _____

Subscriber's Employer Name: _____

SECONDARY INSURANCE

Secondary Insurance Name: _____ ID or Member #: _____

Subscriber Name: _____ Group or Policy Number: _____

Subscriber DOB: _____ Relation to Patient: _____

ASSIGNMENT OF BENEFITS

I hereby authorize assignment of payments directly to Orthopaedic Associates of Marlboro, P.C. for any surgical and/or medical benefits, which are payable to me for this service described above. I understand that I am financially responsible for the charges not covered by this assignment of benefits or my insurance. I hereby authorize Orthopaedic Associates of Marlboro, P.C. to release any information related to medical care received by me for purposes of treatment and/or payment. Furthermore, by signing below, I declare that I have received a copy of Orthopaedic Associates of Marlboro, P.C. privacy precautions.

_____ _____

Signature of Patient/Guardian if under 18 **Date**

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HEALTH ASSESSMENT QUESTIONNAIRE

Name of Patient: _____ Date: _____

Age:_____ Occupation/ Work: _____

Primary Care Physician: _____ Phone: _____

Referred By (ER, Primary Care, Clinic, Employee Health, Med Works, Patient, Etc.): _____

CURRENT ORTHOPEDIC PROBLEM (Why are you here today?): Date of Injury: _____

#1_____

#2_____

HISTORY OF CURRENT PROBLEM (Location, Severity, Timing, Duration):

_____

_____

How long have your symptoms been present?_____ Work Related? ☐ Yes ☐ No

GENERAL MEDICAL CONDITION

Height: _____

Weight: _____

Asthma:	☐ Y ☐ N	Fibromyalgia:	☐ Y ☐ N
Blood Clots:	☐ Y ☐ N	Heart Trouble:	☐ Y ☐ N
Bleeding Tendency:	☐ Y ☐ N	Stroke:	☐ Y ☐ N
Cancer:	☐ Y ☐ N	Stomach Ulcers:	☐ Y ☐ N
Diabetes:	☐ Y ☐ N	High Blood Pressure:	☐ Y ☐ N

Other Medical Conditions/Illnesses/Arthritis: _____

Current Medications: _____

_____

Previous Surgery:_____

List Drug Allergies:_____

RACE: ☐ Declined ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Pacific Islander ☐ White
ETHNICITY: ☐ Declined ☐ Hispanic/Latino ☐ Non Hispanic/Latino
PREFERRED LANGUAGE: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Italian ☐ Japanese ☐ Sign Language ☐ Spanish ☐ Vietnamese ☐ Other: _____

RECREATIONAL & SOCIAL HISTORY

Alcohol Use: ☐ None ☐ Rarely ☐ Socially ☐ Daily Tobacco Use: Packs/Day:_____

Nonprescription Drug Use: Describe: _____

Current Sports/Activities: _____

FAMILY HISTORY (Ages, Major Medical Problems, if Deceased, Cause of Death):

Mother: _____

Father: _____

Siblings: _____

Children: _____

Spouse: _____

☐ Y ☐ N **Previous Questionnaire Reviewed**

☐ Y ☐ N **Change in Health Status**

_____

Signature of Patient/Guardian if under 18

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RECEIPT OF PRIVACY PRACTICES & DISCLOSURE AUTHORIZATION

Date: _____

PATIENT NAME:_____

PATIENT PHONE:_____

PATIENT EMAIL:_____

DO WE HAVE PERMISSION TO:

☐ Y ☐ N Leave a message at the above phone number?
☐ Y ☐ N Leave a message at your place of employment or voice mail?
☐ Y ☐ N Discuss your condition with spouse, partner or children?
☐ Y ☐ N Can your interpreter or friend receive verbal communication from physician?

If yes, Please List whom the Disclosure May be Made:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

My signature below certifies that I have been provided with a written copy of the above named practice's notice of privacy practices.

_____ _____
Signature of Patient or Guardian if under 18 **Date**

FOR OFFICE USE ONLY

☐ **Lic/Photo ID:** _____ ☐ **Lic/Photo ID:** _____
_____ _____