The Wrist and Hand Center
John M. Rayhack, MD

PATIENT REGISTRATION FORM

FOR US TO BEST SERVE YOU, PLEASE COMPLETE AS FULLY AS YOU ARE ABLE AND PRINT CLEARLY

PATIENT INFORMATION

NAME: _____

BIRTH DATE: _____

ADDRESS: _____

_____
CITY STATE ZIP

HOME PHONE #: _____

CELL PHONE #: _____

WORK PHONE #: _____

SPOUSE OR PARENT:_____
(circle which)

TODAY'S DATE: _____

SOCIAL SECURITY #: _____

PRIMARY INSURANCE: _____

SUBSCRIBER: _____

INSURANCE ID #:_____ GROUP # _____

SECONDARY INSURANCE: _____

INSURANCE ID #:_____ GROUP # _____

OTHER INSURANCE: _____

PRIMARY CARE PROVIDER:

☐ **I don't have one** _____

ADDRESS: _____

_____
CITY STATE ZIP

PHONE #: _____FAX #:_____

REFERRING HEALTH CARE PROFESSIONAL (MD, PA, PT, Chiropractor, Friend, etc.):

☐ **No one referred me** _____

ADDRESS: _____

_____
CITY STATE ZIP

PHONE #: _____FAX #:_____

PREFERRED PHARMACY:

☐ **I don't have a preference** _____

ADDRESS: _____

_____
CITY STATE ZIP

PHONE #: _____FAX #:_____

IF YOU WANT A FAMILY MEMBER TO HAVE ACCESS TO SPEAK TO OUR STAFF ABOUT YOUR HEALTH CARE, PLEASE INDICATE THAT PERSON'S NAME AND RELATIONSHIP HERE:

NAME:_____RELATIONSHIP:_____

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NAME: _____

DATE: _____

NEW PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS AS BEST YOU CAN **Handedness:** ☐ Right ☐ Left

Are you claiming Workers' Compensation for this problem? ☐ Yes ☐ No

* **In your own words, please describe your problem or concern:** _____ *

_____

_____

Involved Side: ☐ Right ☐ Left ☐ Both

☐ Pain ☐ Stiffness ☐ Swelling ☐ Mass ☐ Numbness / Tingling
☐ Wound ☐ Deformity ☐ Skin Lesion ☐ Weakness ☐ Other_____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Variable_____

Involved Area:
☐ Neck ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist
☐ Hand ☐ Thumb ☐ Index Finger ☐ Long Finger ☐ Ring Finger ☐ Small Finger

The onset was:
☐ Sudden, beginning on _____/_____/_____
☐ Gradual, first starting _____ ☐ weeks ago ☐ months ago ☐ years ago

How did it happen or start?_____

_____

_____

It feels:
☐ Sharp ☐ Throbbing ☐ Tingling ☐ Cramping ☐ Deep
☐ Dull ☐ Aching ☐ Burning ☐ _____ ☐ Superficial

Symptoms Occur:
☐ with activity ☐ after activity ☐ in the morning ☐ in the evening ☐ at night ☐ constantly
☐ with computer use ☐ at work ☐ when driving ☐ on the phone ☐ _____ ☐ intermittently

Associated Symptoms:
☐ Pain ☐ Stiffness ☐ Swelling ☐ Mass ☐ Numbness / Tingling
☐ Wound ☐ Deformity ☐ Skin Lesion ☐ Weakness ☐ Other_____

What makes it worse?_____

_____

Does anything make it better?_____

_____

Have you had previous surgery for this problem?
☐ No
☐ Yes--details:_____

Treatment, other than surgery, you have had for this problem:
☐ None ☐ Rest ☐ Ice / Heat ☐ Therapy ☐ Splint / Cast
☐ Medications:_____

Previous studies you have had for this problem:
☐ None ☐ X-rays ☐ MRI ☐ Nerve Studies ☐ Other:_____

Are you presently working? ☐ Yes ☐ No

I am accompanied to today's visit by:

First Name: _____ Last Name _____ Relationship _____

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NAME: _____

DATE: _____

PAST MEDICAL HISTORY

☐ AIDS/HIV	☐ Cancer-Breast	☐ Depression	☐ Hepatitis	☐ Sleep apnea
☐ Alcoholism	☐ Cancer-Colon	☐ Diabetes	☐ Kidney Disease	☐ Pacemaker
☐ Alzheimer's	☐ Cancer-Lung	☐ Drug Abuse	☐ Osteoarthritis	☐ Sickle Cell Anemia
☐ Anemia	☐ Cancer-Prostate	☐ Gout	☐ Reflux / Ulcers	☐ Stroke or TIA
☐ Asthma	☐ Chest Pain	☐ Heart Disease	☐ Rheumatoid Arthritis	
☐ Blood Clots	☐ COPD	☐ Hypertension	☐ Seizures	

☐OTHER:_____

_____

FEMALE PATIENTS ONLY: Is it possible you may be pregnant?_____

SURGICAL HISTORY (list all operations you have ever had in your life):

☐ Tonsillectomy, when? _____
☐ Appendectomy, when? _____
☐ Gall Bladder Removed, when? _____
☐ Hysterectomy, when? _____

☐Other:_____

_____

_____

_____

CURRENT MEDICATIONS ☐ **None**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES ☐ **None Known** ☐ **Latex Allergy**

_____ _____ _____

_____ _____ _____

FAMILY MEDICAL HISTORY

(Mother, Father, Siblings, Grandparents)

Disease	Relationship to patient	Disease	Relationship to patient
☐ Alzheimer's	_____	☐ Gout	_____
☐ Anemia	_____	☐ Heart Disease	_____
☐ Arthritis	_____	☐ Hypertension	_____
☐ Asthma	_____	☐ Kidney Disease	_____
☐ Cancer	_____	☐ Osteoporosis	_____
Which kind? _____		☐ Stroke	_____
☐ Depression	_____	☐ Heart Attack	_____
☐ Diabetes	_____	☐ Other:	
☐ Other:	_____	_____	_____
		_____	_____
		_____	_____

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NAME: _____

DATE: _____

SOCIAL HISTORY

Current Job (Adult) or Current Grade In School: _____

Employer (Adult) or School Name: _____

Marital Status: □Single □Married □Divorced □Separated □Widowed

Children: □ None Number of living sons: _____ Number of living daughters: _____

Tobacco: □Yes □No □Quit
Type: _____
(Cigarettes, Cigars, Pipe, Smokeless)
Packs/day _____
Years smoked _____
Year quit _____

Alcohol: □Yes □No □Quit
Amount _____
Frequency _____
Year quit _____

Other Non-Prescription Drugs: □Yes □No □Quit
Type _____
Years used _____
Year quit _____

Diet Drugs:
Type _____

Activity Level:
How many times a week, on average, do you exercise? _____ What kind?_____

REVIEW OF SYSTEMS

Are you presently experiencing any of these symptoms—OTHER THAN THOSE SYMPTOMS RELATED TO TODAY'S VISIT

Constitutional
- □ Weight gain
- □ Weight Loss
- □ Fever
- □ Weakness
- □ Malaise
- □ Insomnia
- □ Fatigue
- □ Chills
- □ Night sweats

Respiratory
- □ Shortness of breath
- □ Cough
- □ Pain with breathing
- □ Wheezing
- □ TB Exposure

Gastrointestinal
- □ Loss of appetite
- □ Nausea
- □ Vomiting □ Blood
- □ Diarrhea
- □ Dark stool
- □ Abdominal pain
- □ Heartburn
- □ Jaundice
- □ Constipation
- □ Bloody stool

Dermatological
- □ Rashes

Metabolic
- □ Cold intolerant
- □ Heat Intolerant

Immunological
- □ Asthma
- □ Contact dermatitis
  Type? _____
- □ Bee sting allergy
- □ Food allergies
  Type of food? _____

HEENT
- □ Headaches
- □ Double vision
- □ Blurred vision
- □ Hearing Loss
- □ Vertigo/World spinning
- □ Difficulty swallowing
- □ Ringing in ears

Cardiovascular
- □ Chest pain
- □ Feel heart beating fast or hard
- □ Fainting spells

Genitourinary
- □ Increased frequency
- □ Urinary urgency
- □ Incontinence
- □ Blood in urine
- □ Frequent night-time urination

Neurological
- □ Seizures
- □ Tremors
- □ Numbness/Tingling
- □ Dizziness/Lightheaded
- □ Loss of coordination
- □ Difficulty walking
- □ Memory loss
- □ Depression

Hematologic
- □ Easy bruising
- □ Easy bleeding

- □ Could be pregnant

Other

_____ _____ _____

_____ _____ _____

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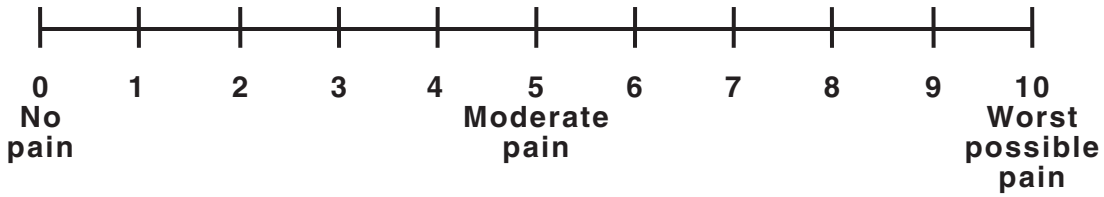
NAME: _____

DATE: _____

Please rate the amount of pain your have in your hand/arm in a typical day:

0-10 Numeric Pain Intensity Scale[1]



Please answer ALL questions, as best as you can:

QuickDASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

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Consent for Care and Treatment
Benefit Assignment/Release of Information
Financial Responsibility Statement

I _____ (Print Name) hereby authorize benefits to be assigned to the Wrist and Hand Center, PA, for healthcare services provided to me. I certify that the insurance information I have provided to Wrist and Hand Center, PA is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility and agree to ensure that my medical bill is paid in full. To this end, I authorize Wrist and Hand Center, PA to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided in good faith and to act on my behalf for the limited purpose of receiving all payments due under my policy/medical care plan for the medical services and care rendered. I further authorize the release of any information pertinent to my care to any insurance company, adjustor, or attorney involved and to request on my behalf, as needed, all levels of appeal and/or any administrative review due me by any applicable Social Security Act, the U.S. Department of Labor, Department of Community Health, or Department of Insurance pursuant to State and/or Federal ERISA Claim Regulatory Guidelines.

I understand under ERISA that I have the right and authority to direct where payment for services rendered is sent and hereby instruct and direct my Insurance Company to pay Wrist and Hand Center, PA directly. I agree and understand that any funds that I may receive by my Insurance Company which are due for services rendered by Wrist and Hand Center, PA will be immediately signed over and sent directly to Wrist and Hand Center, PA. I fully understand that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits based on billed charges, within ninety (90) days of any and all appeals or requests for information. All outstanding patient balances will be subject to a late charge of $25.00 after 60 days. Additional late fees of $20.00 will accrue for each subsequent thirty (30) day period of nonpayment. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable collection expenses.

In an attempt to document physical findings, Dr. Rayhack will occasionally record these findings either on digital video or photographs. I consent to my anonymous (no name identification will ever be used) medical evaluation being documented by Dr. Rayhack.

Wrist and Hand Center PA is required by law to maintain my privacy and to provide a notice of Wrist and Hand Center, PA's legal duties and privacy practices with respect to protected health information. A copy of the Notice of Privacy Rights is available for review upon request or can be downloaded from the following web sites: www.rayhack.com and www.orthodoc.aaos/rayhack. My signature below is an acknowledgement that I have been afforded the opportunity to have a copy of this notice for review.

I authorize Wrist and Hand Center, PA and its associates to provide medical care reasonable by today's standards.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Guarantor Date

_____ _____
Witness Date