REGIONAL ORTHOPAEDIC
SPORTS MEDICINE CENTER

Patient Information

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: ◯ Caucasian ◯ African American ◯ Arabic ◯ Asian ◯ Other _____

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Other _____

Preferred Language: ◯ English ◯ Spanish ◯ Chinese ◯ Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Patient *Information* (***Please neatly print the information*** **needed below, thanks**)

Last Name: _____ First Name: _____ M.I. _____ Date of Birth: ___/___/____

Sex OMOF SSN # _____-_____-_____ Mailing Address: _____

City _____ State _____Zip Code _____-_____

Email Address:_____

Home Phone# (____) _____-_____Cell Phone# (____) _____-_____Work # (____) _____-_____

Employer Name & Address: _____

City _____State_____Zip Code _____-_____May we contact you at work? _____

Primary Care Physician _____ Phone _____

Insurance Information:

Primary Insurance Co: _____Policy or Subscriber #: _____

Address: _____ Group: _____Policy Holder SS#: _____

City_____State_____Zip: _____ Policy Holder Name & D.O.B._____

Secondary Insurance Co: _____Policy or Subscriber

#:_____ Address: _____Group: _____Policy

Holder SS#: _____ City_____State_____Zip: _____Policy Holder Name & D.O.B._____

Responsible Party: COMPLETE IF PATIENT IS A MINOR

Parent/Guardian Name: _____ Social Security # _____-_____-_____

Driver's License# _____ DOB _____/_____/_____

Address (if different) _____

Employer _____Work Phone# (_____) _____-_____

Emergency Contact & Phone Number

Name: _____Phone # _____Relationship_____

CONSENT FOR TREATMENT: I hereby authorize R.O.S.M.C (Regional Orthopaedic & Sports Medicine Center) or Jeffrey Parrett, DPM, P.A. to administer the treatment as may be deemed necessary or advisable in the diagnosis and treatment of the named patient.

RELEASE OF INFORMATION: I authorize R.O.S.M.C. or Jeffrey Parrett, DPM, P.A. to obtain and/or release any medical information requested by representatives of local, state, or federal agencies, insurance companies, Workman's compensation carriers, the patient's or guarantor's employer, or other organizations or entities as may be required for payment of claim, work, or treatment of patient.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier to make payment directly to R.O.S.M.C., Robert P. Roye, M.D., Susan Chiusano, FNP-C or Jeffrey Parrett, DPM, P.A. For charges incurred. I further assign all right to payment due me for medical and/or surgical services to R.O.S.M.C. or Jeffrey Parrett, DPM, P.A.

FINANCIAL RESPONSIBILITY: I understand that all co-pays, deductibles etc. are due when services are rendered. I understand that although R.O.S.M.C. or Jeffrey Parrett, DPM, P.A. will, as a courtesy to me, file my claim with my insurance carrier. I am ultimately the responsible party for all charges incurred.

Signature of Patient or Guardian _____ **Date** _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Regional Orthopaedic & Sports Medicine Center's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I hereby authorize ROSMC to release my information to:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

_____

Signature of Patient or Personal Representative

_____

Date

PAIN MEDICINE GUIDELINES

At some point in your treatment, Dr. Robert Roye, or Dr. Jeff Parrett and Susan Chiusano NP, may prescribe a medication to help control your pain. This will likely be a controlled substance or narcotic. These medications have a high potential for abuse and misuse and are closely controlled by the local, state and federal governments. If used excessively, the medications can cause serious adverse effects such as lethargy, respiratory depression, liver failure and even death. Certain guidelines must be followed in order for patients to receive these medications. Please read carefully and sign below to indicate that you will comply with the guidelines. A copy of this agreement will be placed in your chart.

1. Read the instructions on your medication bottle. Take the medication ONLY as directed.
2. All patients are expected to abide by the dosing directions that are on your prescription bottle. It is not our intent that you should be in pain. If you feel that your medication is not controlling your discomfort, please call our office for an appointment.
3. NO PRESCRIPTION WILL BE REFILLED BEFORE IT IS DUE.
4. If your medication is due for a refill, please call your pharmacy and give them the request. The pharmacy will then call our office and request the refill. It is not necessary for the patient to call the doctor's office for the refill. This can unnecessarily delay your refill.
5. Most calls to pharmacies are returned at or after 5:00 PM when our clinic is over.
6. If your medication is lost or stolen, the office will be unable to refill it early. It is the patient's responsibility to keep narcotics and other medications in a safe place.
7. If your refill is due on a weekend, please call the pharmacy a couple of days early so that our office may authorize the refill for Saturday or Sunday as appropriate.
8. NO PRESCRIPTIONS WILL BE REFILLED AFTER 2:00 PM ON FRIDAY. NO PRESCRIPTIONS WILL BE REFILLED ON WEEKENDS, NIGHTS, AND HOLIDAYS OR ON AN "EMERGENCY" BASIS.

I have read the guidelines stated above and agree to abide by the Recommendations.

_____ _____

Patient's signature / Guardian Signature Date

_____ _____

Name of Patient

FALL RISK ASSESSMENT

PLEASE CHECK	YES	NO
I have fallen in the past year *People who have fallen once are likely to fall again.*	○	○
I use or have been advised to use a cane or walker *People who have fallen once are likely to fall again*	○	○
Sometimes I feel unsteady when I am walking *Unsteadiness or needing support while walking are signs of poor balance.*	○	○
I steady myself by holding onto furniture when walking at home *This is also a sign of poor balance*	○	○
I am worried about falling *People who are worried about falling are more likely to fall*	○	○
I need to push with my hands to stand up from a chair *This Is a sign of weak leg muscles*	○	○
I have some trouble stepping up onto a curb *This is also a sign of weak leg muscles*	○	○
I often have to rush to the toilet *Rushing to the bathroom, especially at night, increases your chance of falling*	○	○
I have lost some feeling in my feet *Numbness in your feet can cause stumbles and lead to falls.*	○	○
I take medicine that sometimes makes me feel light-headed or tired *Side effects from medicines can sometimes increase your chance of falling*	○	○
I take medicine to help me sleep or improve my mood *These medicines can sometimes increase your chance of falling*	○	○
I often feel sad or depressed *Symptoms such as not feeling well or feeling slowed down, are linked to falls*	○	○

PATIENT SIGNATURE & DATE: _____

TOTAL:

If you scored 4 or higher, you may be at risk for falling. Discuss your results with your Doctor.