ORTHOPAEDIC ASSOCIATES OF WAUSAU / PRO PHYSICAL THERAPY & HAND CENTER
PATIENT REGISTRATION FORM

1. PATIENT INFORMATION

Name ____ Maiden/Former Name ____________________

Social Security No ________________ Date of Birth _____________ Employer ___________________________

Email Address ____ Do you want Portal Access: Yes ☐ No ☐

Race: White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American/Alaskan Native ☐ Unknown ☐

Ethnicity: Latino/Hispanic ☐ Not Hispanic or Latino ☐ Other ☐ Unknown ☐ Marital Status: __________ Gender: _______

Primary Care Physician _______________________________________ Facility: ______________________

Do you make your own healthcare decisions? Yes ☐ No ☐

If no, who is your POA? ____

Relationship _________________________ **Telephone Number** _________________________

2. INSURANCE COVERAGE INFORMATION

ALL patients must answer →

Are you being seen for a work-related injury/condition? _______Y _______N

At this time, I, ______________________________, represent and warrant that I
(Print Your Name)
(DO) or (DO NOT) have **Medicaid coverage.**

Circle One *– If unmarked, default is a representation that you do not have Medicaid currently. If you are completing this form on a system where you cannot* ***circle one****, please inform the staff immediately if you have Medicaid health insurance coverage.)*

3. ASSIGNMENT AND RELEASE OF INFORMATION

MEDICARE: I request that payment of authorized Medicare benefits be made to Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian ____ Date ____________________

ALL PATIENTS: I hereby authorize the offices of Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau (OAW/PRO), to release any medical information required during the course of examination and treatment to my insurance company(ies), and I permit payment to OAW/PRO from my insurance for any benefits due for their services rendered. I permit a photographic or other facsimile of this authorization to be used in place of the original. **I agree to pay those charges which may not be paid by my health insurance and are my responsibility per insurance benefits.**

Patient/Guardian ____ Date ____________________

4. PRESCRIPTION HISTORY

I agree that OAW/PRO may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes.

Patient/Guardian ____ Date ____________________

5. PATIENT COMMUNICATIONS

I authorize OAW/PRO to contact me at the phone number(s) and e-mail address I provided during my registration as a patient. OAW/PRO may contact me via phone call, text message, or e-mail. The messages may be automated, autodialed, prerecorded calls and/or texts to communicate appointment reminders, notifications regarding the availability of path or lab results, billing and collection information. I understand that I am not required to give the consent as a condition of receiving medical care or goods. I may revoke my consent to receiving such calls and/or messages at any time by contacting OAW/PRO in writing, by phone, or by following the automated prompts provided in those messages.

Patient/Guardian ____ Date ____________________

6. PRIVACY

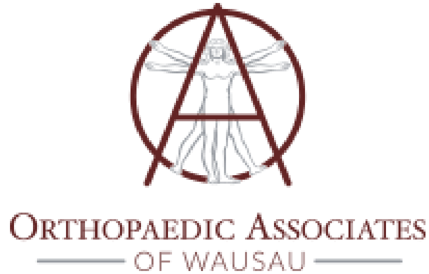
I acknowledge I have been provided or offered a copy of the Privacy Practices of Orthopaedic Associates of Wausau/PRO Physical Therapy and Hand Center (OAW/PRO). These can also be accessed on our website at oaw-ortho.com.

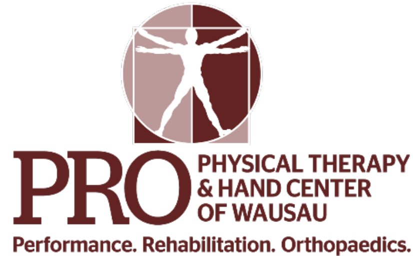
Patient/Guardian ____ Date ____________________

DISCLOSURE/DISCLAIMER OF OWNERSHIP

PRO Physical Therapy & Hand Center of Wausau is a division of Orthopaedic Associates of Wausau, and is fully owned and operated as part of their comprehensive services that they deliver for their patients. As an OAW patient, there is no obligation for you to receive physical therapy and occupational therapy services at our clinic, and as always, you have the right to choose any rehab provider or location that you desire.

Orthopaedic Associates of Wausau and PRO PT complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.





Please review our office policies regarding financial responsibility, behavior and prescription refills. You may view a copy of these policies at our reception desk or on our website at www.oaw-ortho.com. You can request a printed copy of these policies from our reception team.

Please initial each line item below:

______ I have reviewed the OAW/PRO Respect Policy.

______ I have reviewed the OAW Prescription Refill Policy.

______ I have reviewed the OAW/PRO Financial Policy.

Please sign and date that you understand and acknowledge these policies.

Patient/Guardian____ Date______________________

DISCLOSURE OF RECORDS

This form is intended to identify those individuals (family members, close friends, or other persons) to whom we can disclose your protected health information or notify them regarding your care. This form will remain in force until you provide us with written notice otherwise.

☐ **I am the only person who is to have access to my medical and billing information.**

Emergency Contact:

Name ____

Address ____

Telephone _________________________ Relationship __________________

☐ Emergency Contact Only ☐ May Disclose Medical and Billing Information ☐ May Disclose Medical Information Only ☐ May Grant Portal Access (includes Medical and Billing)

Other Contacts for Disclosure of Records:

1. Name ____ ☐ Medical and Billing

Address ____ ☐ Medical Only

Telephone _________________________ Relationship ______________________ ☐ Portal (included Medical & Billing)

2. Name ____ ☐ Medical and Billing

Address ____ ☐ Medical Only

Telephone _________________________ Relationship ______________________ ☐ Portal (included Medical & Billing)

I agree that protected health information regarding my care and/or treatment may be disclosed to the above-named individuals. This Authorization will remain in effect until I provide written notice to change it.

Signed ____ **Date** __________________

If this form is being signed by a **Patient's Authorized Representative**, please complete the following:

Representative's Name ____

Relationship to patient and reason for signing: _______________________________________

ORTHOPAEDIC ASSOCIATES OF WAUSAU PATIENT HEALTH HISTORY FORM

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.

Full Name: ______________________________ Gender: __________ Date of Birth: ______________

Do you have an Advanced Directive? Yes ☐ No ☐ If no, would you like information on how to get one set up? Yes ☐ No ☐

Medication List: *List prescribed medications, vitamins, herbal, inhalers, and/ or diet supplements.*

Medication	Dosage	Reason for taking this medication

Allergies:

Type	Reaction

Do you have any of the following:

Allergy to any of the following?

Adhesive Tape	☐ No	☐ Yes
Iodine	☐ No	☐ Yes
Contrast Dye	☐ No	☐ Yes
Metal	☐ No	☐ Yes
Latex	☐ No	☐ Yes
Family history of Malignant Hyperthermia	☐ No	☐ Yes

Implanted devices: ______________________________
Prosthesis (type): ______________________________
Hearing aid (R/L): ______________________________
Dentures/ Partial (upper/lower): ______________________________
Glasses/ contacts (R/L): ______________________________
Are you Right ☐ or Left ☐ handed

Do you have any history of:

- ☐ High Blood Pressure
- ☐ Frequent Headaches
- ☐ Ulcer
- ☐ GERD
- ☐ Stomach Pain
- ☐ Diabetes, type ______________
- ☐ Mental Illness
- ☐ Spinal Cord injury
- ☐ Blood Clots
- ☐ HIV/ AIDS
- ☐ Jaundice/ Liver Disease
- ☐ Kidney Disease
- ☐ Heart Attack
- ☐ ADHD
- ☐ Angina
- ☐ Heart Murmur
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Seizures/ Epilepsy
- ☐ Stroke
- ☐ Fainting Spells
- ☐ Paralysis
- ☐ Eczema/ Psoriasis
- ☐ Raynaud's Syndrome
- ☐ Anxiety
- ☐ Depression
- ☐ COPD
- ☐ Arthritis, type______________
- ☐ Cancer, type ______________
- ☐ Excessive Bleeding
- ☐ High Cholesterol/ Lipids
- ☐ Blood Transfusion
- ☐ Thyroid Disease
- ☐ Sickle Cell Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ Numbness, location ______________
- ☐ Tingling, location______________
- ☐ Other ______________

If you ever received a cortisone or steroid injection, please list the body part and how many times it has been injected. ______________

____

Surgeries:

Procedure	Hospital	Date

Family Health History:
Please list any problems that run in your family to include bad reactions to anesthesia, easily bruised or bleeding, diabetes, cancer, heart attack before age of 55, arthritis, etc.

	Age	Gender	Significant Health Problems		Age	Gender	Significant Health Problems
Father				Child		☐ M ☐ F	
Mother				Child		☐ M ☐ F	
Sibling		☐ M ☐ F		Child		☐ M ☐ F	
Sibling		☐ M ☐ F		Grandparents		☐ M ☐ F	

Bone Health: *Check any of the below that you have had.*

☐ Fracture from a fall or low impact injury
☐ Fracture of the wrist, spine or hip
☐ Vitamin D Deficiency
☐ Frequent falls
☐ Long term use of steroids (Name of steroid and what you took it for)
____
☐ Had a Bone Mineral Density Test (DXA Scan). If yes, when and where?
____
☐ Had treatment for Osteoporosis. If yes, what and when?
____

Social History:

☐ Work in the home?	☐ Employed (occupation______________________)		☐ Student	☐ Daycare	☐ Retired
☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	
Children?	☐ No	☐ Yes	How many? _____________		
Do you live alone?	☐ No	☐ Yes			
Exercise?	☐ Daily	☐ Weekly	☐ Monthly	☐ Rarely	☐ Never
What type of exercise? ____________________________					
History of substance abuse?	☐ No	☐ Yes	What? ____________________________		
Have you ever been or are you currently on a pain contract?	☐ No	☐ Yes	With Whom? ____________________		
Current Tobacco User?	☐ No	**Type:**	☐ Cigarettes: Packs/quantity per day ______	☐ E-Cig/Vape	☐ Smokeless Tobacco
Quit smoking?	☐ This year	☐ Less than a year	☐ Less than five years	☐ Less than 10 years	
Previously smoked ___________ packs per day for _____________ years.					
Drink alcohol?	☐ No	☐ Daily	☐ 1-2 times a week	☐ 1-2 times per month	☐ 1-2 times per year

Patient Signature: ____ Date: ________________

***** ONLY COMPLETE IF YOU ARE HERE FOR PRO PHYISCAL THERAPY: *****

Reason for attending therapy? ____

Date symptoms occurred: ___________ Cause of your injury: ____________________________

What makes your symptoms worse: ____

What makes your symptoms better (please circle): Ice Heat Meds Rest Activity Massage Other: ______________

Main Goal(s) for Therapy: ____

Have you ever had treatment for this problem before: ☐ Yes ☐ No

- If Yes, what kind of treatment have you had (please circle): PT OT Chiropractic Massage Therapy Other: __________

What is your preferred learning style(s) (please circle): visual/seeing auditory/hearing tactile/doing (performance)

Is this Worker's Compensation: ☐ Yes ☐ No

- If yes, do you have work restrictions? ☐ Yes ☐ No If yes, what are they: ______________________
- How many hours a week do you normally work? ______________
- Have you returned to work? ☐ Yes ☐ No
  - If yes, at what capacity? How many hours per week are you currently working? ______________________
  - Are you performing your normal work duties? ☐ Yes ☐ No If No, please explain: ______________________

Patient Signature: ____ Date: ________________