

Patient Registration Form
Galveston Physical Medicine
2724 61st #5
Galveston, Texas 77551
Office: 409-744-9355 • Fax: 409-744-9356

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home: () _____ Work: () _____ Cell: () _____

S.S.N.: _____ Date of Birth: _____ Age: _____

Gender: Male Female Email Address: _____

Marital Status: Married Divorced Single Widowed

Referring Physician: _____ Reason for your visit? _____

Phone: () _____

Address: _____
Street City State Zip Code

Employer or School: _____ Address: _____

Emergency Contact: _____ Relation: _____ Phone: () _____

Spouse's Name: _____ S.S.N.: _____

Spouse's Date of Birth: _____ Employer: _____

Spouse's Phone: () _____ Are you insured under their policy? Yes No

Responsible Party Name and Address (Under 18):

Relation to Patient: _____

Date of Birth: _____ Employer: _____ Phone: () _____

Health/Medical Insurance Yes No Self-Pay

PATIENT INSURANCE INFORMATION TO BE COMPLETED ON PATIENT INSURANCE FORM ATTACHED

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

Signature: _____ **Date:** _____

Galveston Physical Medicine
Authorization for Release of Information

Patient Name: _____ DOB: ___/___/___ SSN: ____-____-____

Address: _____

Home Phone: () _____ Cell Phone: () _____

I authorize: _____

Physician Name	Facility Name	Facility Phone

Facility Address	Facility Fax	

To send/release photocopies of medical records concerning the above named person to:

Galveston Physical Medicine
2724 61st #5
Galveston, Texas 77551

For the purpose of treatment for _____. I authorize the release of photocopies of the following medical records and information in their possession including all confidential HIV related information, confidential alcohol or drug abuse related information and confidential mental health diagnosis and treatment information. I agree that these provisions will remain in effect until I provide written revocation to Galveston Physical Medicine.

- Medical Records Hospital Records Procedure Records Laboratory Records
- _____ Inpatient _____ Outpatient Other

Signature of Patient/Legal Guardian **Relationship to Patient** **Date**

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable disease) requested by my health insurance carrier, Medicare or any other third-party payers, and I authorize Galveston Physical Medicine to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Galveston Physical Medicine.

I agree that these provisions will remain in effect until I provide written revocation to Galveston Physical Medicine.

Signature of Patient/Legal Guardian **Relationship to Patient** **Date**

Galveston Physical Medicine
Patient Consent Form

I, _____, understand that as part of my health care, that Galveston Physical Medicine creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with a *Notice of Privacy* which provides a more complete description of information uses and disclosures.

I understand that Galveston Physical Medicine is not required to agree to the restrictions requested and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Federal and State Regulations.

I further understand that Galveston Physical Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Federal and State Regulations.

Galveston Physical Medicine has my consent to give out my private health information, including my identity, diagnoses and treatments, whether in writing or verbally, to the following persons or entities (e.g. spouse, child or other representative):

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

I understand that as required for Galveston Physical Medicine's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient or Guardian

Witness

Date

Date

Date: _____

Name: _____

ID: ____/____/____

KNEE CONSULTATION QUESTIONNAIRE

Womac Osteoarthritis Index

Pain: The following questions concern the amount of pain you are currently experiencing in your knees. Indicates the level of pain associated with:

	None	Mild	Moderate	Severe	Extreme
1. Walking on flat surface	0	1	2	3	4
2. Up or Down Stairs	0	1	2	3	4
3. At night while in bed	0	1	2	3	4
4. Sitting or Lying	0	1	2	3	4
5. Standing Upright	0	1	2	3	4

Stiffness: 1.) How severe is your stiffness after first awakening in the morning?

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

2.) How severe is your stiffness after sitting, lying, or resting later in the day?

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

Physical function: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. What degree of difficulty do you have with:

	None	Mild	Moderate	Severe	Extreme
1. Descending Stairs	0	1	2	3	4
2. Ascending Stairs	0	1	2	3	4
3. Rising from sitting	0	1	2	3	4
4. Standing	0	1	2	3	4
5. Bending to the floor	0	1	2	3	4
6. Walking on a flat surface	0	1	2	3	4
7. Getting in/out of car	0	1	2	3	4
8. Going shopping	0	1	2	3	4
9. Putting on socks	0	1	2	3	4
10. Rising from bed	0	1	2	3	4
11. Taking off socks	0	1	2	3	4
12. Lying in bed	0	1	2	3	4
13. Getting in / out of bath	0	1	2	3	4
14. Sitting	0	1	2	3	4
15. Getting on /off toilet	0	1	2	3	4
16. Heavy duties (moving)	0	1	2	3	4
17. Light duties (cleaning)	0	1	2	3	4

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | |

Do you exercise: Never Daily Weekly Walks Runs Swims

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ DATE _____

Reviewed by Provider: _____ (initials)