The Center *for* Bone and Joint Health

Thank you for choosing The Center for Bone and Joint Health for your care. The providers and staff welcome you!

To simplify the registration process during your first visit we ask that you take a moment to review and complete the attached paperwork. If you have questions, please contact the office directly and our staff will be happy to assist you. We ask new patients to arrive 10-15 minutes early for the first visit to complete the registration process without delaying your appointment.

Please bring the following information to your appointment.

- Completed registration paperwork
- Insurance card(s)
- Referral from your primary care provider if needed
- All X-Rays, MRI's, or other imaging related to your appointment. Please bring a copy of all imaging taken at any facility other than Southern New Hampshire Medical Center on a disk.
- Complete list of medications you're taking, including over the counter medications, herbs and supplements
- Insurance co-payment or payment which is due at the time of service
- If your visit is due to a work related injury, the following Worker's Compensation information is required for your appointment:
  - Claim number
  - Date of injury
  - Name, address and phone number of insurance company
  - Contact person at insurance company
  - Employers name and address

All patients under the age of 18 must be accompanied by a parent or guardian.

Our goal is to provide you with exceptional care and we do our best to schedule your time appropriately. Some visits and procedures may take longer than we anticipate; we will keep you informed of delays and wait times and appreciate your patience during these occasional times.

Thank you. We look forward to working with you to ensure your health care needs are met.

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Patient Information

Patients Name:_____ Sex: M/F

Last First Middle Initial

Birthdate:_____/_____/_____ Age:_____ Marital Status M/S/D/W

Place of Birth: _____

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

Street Address:_____ Social Security Number: _____ /___/____

City: _____ State:_____ Zip:_____ How long:_____

Mailing/Permanent Address (if different from above):

Street/Apt#: _____City:_____State:_____ Zip:_____

Your Employer:_____ Occupation:_____

Employers Address:_____ City_____ State:_____ Zip:_____

Person to Notify in case of emergency:_____ Phone Number: _____

Referred By:_____

If Patient is not the main subscriber of insurance, please complete below:

Name of Subscriber:_____ Date of Birth:_____

Social Security Number: _____/_____/_____ Home Phone Number:_____

Address:_____ City: _____ State:_____

Health Questionnaire

Have you ever smoked cigarettes? Yes:____ No:___ How many packs per day? _____ How long?_____

Have you stopped? Yes_____ No_____ How Long?_____

Do you presently use alcohol? Yes:____ No:____Amount per day (include beer and wine)_____

Have you ever had an alcohol problem?_____

Do you use street drugs?_____ How often:_____

Have you ever had a problem with street drugs?_____

Do you use seat belts?_____

How many cups of coffee do you drink per day?_____ Caffeinated:_____

Do you exercise?_____ How many times per week? _____

Eating Habits: Do you limit or enrich your diet in any way? _____

What do you consider your ideal weight? _____

Stress: Do you consider yourself under excessive stress? _____

Do you have problems with sleep?_____

(FEMALE ONLY) Periods began at age:_____ Regular? _____

Menopause? ____ Age: _____ Times Pregnant? _____ Miscarriages/Abortions: ____

Give Names and dates of any surgeries:

Give names of illnesses which have required hospitalization:

Do you have any chronic medical conditions?

Please supply a list of your current medications includes Herbs and Supplements (Give name, strength, and frequency):

Any known allergies to medications? _____

Immunizations (include dates): Tetanus:_____ Hepatitis B_____ Pneumonia _____

Family History:

		Age	Health Problems	Age at death	Cause
Father					
Mother					
Brother/Sister					
Other:					
Husband/Wife					
Sons/Daughters					

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Missed Appointment Policy

We make every effort to schedule appointments at times that are convenient for our patients. We understand that despite careful planning, sometimes emergencies arise that necessitate cancellation. Because we reserve your appointment specifically for you, we ask that you kindly give us a 24 hour notice if you will be unable to keep your appointment.

If you miss three scheduled appointments without 24 hour notification, our office will work with you to determine the next steps for your care.

We do our very best to stay on time and you being on time helps make that happen. We pledge to keep you informed of any delays and give you options to reschedule, if necessary, by working with you to find an appointment time that best fits your needs.

We look forward to working with you to ensure your health care needs are met.

I have read and understand the information above:

_____ _____/_____/_____
Patient Name (Please Print) Date of Birth

_____ _____/_____/_____
Patient or Guardian Signature Date

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Patient Consent to Share PHI

(Protected Health Information)

Patient Name:_____ DOB:_____

In addition to allowable disclosures described in the "Notice of Privacy Practices," I hereby specifically consent to disclosure of my protected health information (PHI) to the person(s) indicated below who are involved in my care. (Please provide full name/s)

- Any member of my immediate Family (husband/wife/children/parents):

  _____

  _____

- Spouse Only:

  _____

- Other:

  _____

  _____

I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian Signature Date

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Notice of Health Information Privacy Practices

The confidentiality of your health information has always been a priority in our office.

You may access our Privacy Notice on our website or you may request one upon arrival. The Privacy Notice will explain how we use, or do not use, your health information.

Please sign this acknowledgement stating that you have reviewed a copy of this notice.

_____ _____/_____/_____
Patient Name (Please Print) Date of Birth

_____ _____/_____/_____
Patient or Guardian Signature Date