PLEASE ARRIVE 30 MINUTES BEFORE APPOINTMENT TIME

PLEASE FILL OUT THE ENCLOSED PAPERWORK AND BRING IT TO YOUR APPOINTMENT ALONG WITH THE FOLLOWING:

1. All insurance cards that you want us to file with. We will need the actual card to obtain all of the proper information.
2. All x-rays, MRI's, bone scans, etc., that you have had done in the last 6 months.
3. A list of your medications and allergies.
4. Past medical records that you feel are necessary for our physician to review and provide treatment.
5. Name, address, and phone numbers of your referring physician and family physician so we can send a medical report to them.

INSURANCE INFORMATION

HMO/POS/PPO: If you are covered under an HMO, POS, or PPO insurance plan, please contact your family physician for a referral if needed. It is your responsibility to obtain the referral.

SELF-PAY: You, the patient, are responsible for payment if you have no insurance coverage, are involved in a liability case, or have incomplete insurance information. We will try to assist you in collecting from your insurance company, but *you* will still be responsible for payment of your bill.

We look forward to serving your orthopaedic needs.

Thank you

Franciscan PHYSICIAN NETWORK

REGISTRATION FORM

Date: __________________

Patient Name: ____ Sex: ☐ F ☐ M
Last First Middle

Social Security #: ______________________ Birth Date: ______________________

Address: ______________________________ ______________________________
Street/Apt # City / State / Zip Code

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email Address: ______________________________ Language: ______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(ed) Ethnicity: ________ Religion: ________ Race: ________

Primary Care Physician: ______________________ Referring Physician: ______________________

Preferred Pharmacy Name & Phone: ______________________________________

Employer/School: ______________________________ Occupation ______________

Address: ______________________________ ______________________________
Street/Apt # City / State / Zip Code

Phone: ______________________________ Fax: ______________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

Spouse's Name:______________________ Employer:______________________ Work Phone:______________

Address:____

Phone:______________________ Work Phone:______________________ Mobile Phone:______________

If patient is a minor, parent/legal guardian is: ______________________ Relationship to patient:______________

Emergency Contact ______________________________ Relationship to Patient ______________

Emergency Contact Home Phone ______________________ Cell Phone ______________________

WHO SHOULD RECEIVE THE BILL

Name:______________________ Relationship to Patient:______________ Sex: ☐ F ☐ M

Social Security #:______________________ Birth Date:______________________ Phone:______________

Address:____

Employer:______________________________ Work Phone:______________________

Employer Address: ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

MEDICAL INSURANCE INFORMATION

First (Primary) Insurance Co.:____

Insurance Co. Address:____

Policy Holder's Name:______________________________ Relationship to Patient:______________

Policy Holder's Birth Date:______________ ID:______________ Group/Policy #:______________

Policy Holder's Employer:______________________________ Social Security #:______________

Effective Date:______________

Secondary Insurance Co.:____

Insurance Co. Address:____

Policy Holder's Name:______________________________ Relationship to Patient:______________

Policy Holder's Birth Date:______________ ID:______________ Group/Policy #:______________

Policy Holder's Employer:______________________________ Social Security #:______________

Effective Date:______________

Franciscan
PHYSICIAN NETWORK

Anthony Feher, M.D.
Jeffery Pierson, M.D.
12188-B North Meridian, Suite 250
Carmel, IN 46032
(317) 706-2361
(317) 706-2362 fax

Medical History and Information

Patient Name ______________________________ Date _____/_____/_____
Age ___________ Circle one: Male Female Birthdate _____/_____/_____
Occupation (if retired, former occupation)______________________________
Referring Doctor: ______________________________

Present Complaint (Please circle) ❒ **left** ❒ **right** ❒ **both**
❒ **hip** ❒ **knee**

Date of onset and length of problem: ______________________________
Was the problem caused by an accident or injury? **Yes** **No** If yes, what type of incident? ______________________
______________________________ Date _____/_____/_____
Have you ever had surgeries on the above area? **Yes** **No**
If yes, please describe the most recent surgery: type of surgery: ______________________________
Date of surgery: _____/_____/_____ Name of surgeon: ______________________________
Please list other surgeries on this area prior to the one above: ______________________________
____

PAST MEDICAL HISTORY

Have you been treated for any of the following illnesses? (please check any that apply)

❒ High blood pressure	❒ Depression	❒ Cancer
❒ Heart disease/heart attack	❒ Immunodeficiency	❒ Stroke
❒ Emphysema/Bronchitis	❒ Hepatitis	❒ Ulcers
❒ Bleeding disorder	❒ Diabetes	❒ Epilepsy

Please comment on any illness checked above or write in other condition. ______________________________
____

Please list other previous **surgeries**, complications, and year of surgery:______________________________
____
____

List all current **medications** you take on a regular schedule (include non-prescription meds)

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Over

Medical History and Information

Patient name______________________________ Birth date____/____/____

Are you **allergic** to any medication or food? ❐ Yes ❐ No

If Yes, please list:

Medications/Food	Reaction
______________	______________
______________	______________
______________	______________

FAMILY HISTORY

Please list all diseases that run in your family (for example: diabetes, arthritis, bleeding disorders, or anesthetic problems).

____

____

Mother is (circle one) **alive** **deceased.** If deceased, died of ______________ Age______

Father is (circle one) **alive** **deceased.** If deceased, died of ______________ Age______

SOCIAL HISTORY

Marital Status (circle one): ❐ Married ❐ Single ❐ Divorced ❐ Widowed

Do you smoke or use tobacco? Yes No If yes, how much per day?______________

Do you drink alcohol? Yes No If yes, how much?______________

REVIEW OF SYSTEMS (Check all that apply and explain.)

SYSTEM	EXAMPLES	LIST OTHER PROBLEMS
❐ General	fever, weight loss, fatigue, weakness	______________
❐ Eyes	glasses, visual disturbances, dryness	______________
❐ Ear, Nose, Throat	vertigo, sinusitis, hoarseness	______________
❐ Heart	chest pain, palpitations, murmurs	______________
❐ Lungs	short of breath, asthma, cough, wheezing	______________
❐ Circulation	clots, edema, varicosities, claudication	______________
❐ Digestive Tract	diarrhea, constipation, ulcers, pain	______________
❐ Kidney, Urinary	stones, burning, urgency, bleeding	______________
❐ Skin, Breast	rashes, lumps, itching, hair/nail changes	______________
❐ Endocrine	excess thirst, decreased energy	______________
❐ Neurologic	stroke, seizures, tremor, weakness	______________
❐ Psychiatric	depression, sleep disturbances, anxiety	______________
❐ Blood, Lymph	easy bruising, blood disorders	______________
❐ Musculoskeletal	fracture, arthritis, loss of motion, cramps	______________

Factors That May Affect Learning

Who is to be taught: ❐ patient ❐ other; if other, name and relationship to patient______________

Able to read: ❐ yes ❐ no ❐ with difficulty Potential barriers to learning: ❐ none ❐ blind ❐ poor vision ❐ deaf ❐ decreased hearing ❐ unable to talk ❐ learning disability ❐ inability to understand ❐ memory loss ❐ language, if other than English__________ Learns best by: ❐ reading ❐ verbal instruction ❐ practicing ❐ talking ❐ watching ❐ other:______________ Are there any cultural or religious beliefs that need to be considered in the care? ❐ yes ❐ no If yes, ______________

Signature______________ Relationship to patient______________ Date__________

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PATIENT QUESTIONNAIRE

Date_______/_______/_______

Name____Birthdate_______/_______/_______

Reason for visit:____

(if surgery follow-up) Type:_______________________________________Date:_______/_______/_______

Please Check one.

Please describe your pain:
❒ None
❒ Mild
❒ Walking and/or stairs only
❒ Moderate
❒ Marked, continuous with serious limitations
❒ Severe, totally disabling

Do you experience pain when you are walking?
❒ None/or you ignore it
❒ Mild/occasional or intermittent
❒ Mild stairs only
❒ Mild stairs only and level walking
❒ Moderate/pain each day
❒ Severe/constant disabling pain

Do you use support while walking?
❒ None
❒ Cane, long walks
❒ Cane, full time
❒ Crutch
❒ Walker or 2 canes
❒ 2 crutches
❒ Unable to walk

How do you go up and down stairs?
❒ Normally
❒ Normally with rail
❒ Rail up, normal down
❒ Normal up, rail down
❒ Any other method
❒ Unable

How do you reach your feet/shoes & socks?
❒ With ease
❒ With difficulty
❒ Unable

Do you have thigh pain? ❒ Yes ❒ No

Do you experience pain at rest?
❒ None
❒ Mild
❒ Moderate
❒ Severe

How much do you limp without using support?
❒ None
❒ Slight
❒ Moderate
❒ Severe
❒ Unable to walk

Do you need assistance getting out of bed?
❒ I can get out of bed on my own
❒ I need the assistance of another person

Are you able to use public transportation? (i.e. bus, taxi)
❒ Able to enter
❒ Unable to enter

How far can you walk without stopping because of pain?
❒ Unlimited
❒ 6-10 blocks
❒ < 5 blocks
❒ Short distances/indoors only
❒ Confined to wheelchair or bed

Do you have problems with sitting?
❒ Any chair, 1 hour
❒ High chair, 1/2 hour
❒ Unable to sit 1 hour in any chair

For office use only:

HT:__________ WT:__________ BMI:__________ MD:______________________________Date:______________

ROM: Knee L:_________ to _________ Knee R:_________ to _________ Lig exam:________________

Hip L:_______PFC to ________/________/________/________/________LLD:________________ Pulses:__________

Hip R:_______PFC to ________/________/________/________/________Trendelenburg:__________

Patient Instructions for Communication Preferences

Patient Name (*Please Print*):____

Patient Address:____

Date of Birth:________________ Last 4 Digits of Social Security #______________

I authorize my doctor or staff to **leave messages** including certain medical information:

☐ NO Do not leave messages on my answering machine or voice mail. I prefer that my doctor or staff speak to me personally regarding any medical information.

☐ YES May leave messages on my answering machine or voice mail:

☐ at HOME ☐ at WORK ☐ on my MOBILE / CELL PHONE

☐ YES May share information with the following individuals:

☐ My spouse or significant other ______________________________
☐ My son or daughter ______________________________
☐ Any relative ______________________________
☐ Other ______________________________

This information may include information such as:

☐ Lab test and x-ray results ☐ Instructions regarding treatments or medications
☐ Information regarding prescription refills ☐ All information, no exceptions
☐ Information regarding appointments ☐ Billing information

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

______________________________ ______________________________
Signature Date

JOINT REPLACEMENT SURGEONS

Carmel

FRANCISCAN HEALTH – CARMEL
FRANCISCAN PHYSICIAN NETWORK
JOINT REPLACEMENT SURGEONS
12188-B N. Meridian Street, Suite 250
Carmel, IN 46032 Phone: (317) 706-2361

Directions from the north: *Traveling south on US 31, take exit 125 to 116th Street. Turn right (west) onto 116th Street to the roundabout at Illinois Street. Take the first exit off the roundabout (north) on to Illinois Street. The office, located at 12188-B N. Meridian Street, will be about a half mile up on your right.* ***Directions from the south:*** *Traveling north on US 31, take exit 125 to 116th Street. Turn left (west) onto 116th Street to the roundabout at Illinois Street. Take the first exit off the roundabout (north) on to Illinois Street. The office, located at 12188-B N. Meridian Street, will be about a half mile up on your right.*

12188-B N. Meridian Street, Suite 250 | Carmel, IN 46032 | (317) 706-2361