Jacob D. Rozbruch, MD
Orthopaedic Surgery

Patient Label

PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)	PREFERRED NAME	DATE OF BIRTH	SOC.SEC. NUMBER

SEX ASSIGNED AT BIRTH FEMALE MALE INTERSEX	SEX LISTED WITH HEALTH INSURANCE FEMALE MALE	WHAT IS YOUR GENDER IDENTITY? SAME AS SEX LISTED WITH INSURANCE OTHER: ______	PREFERRED PRONOUNS She/Her Ze/Hir He/His/Him

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E-MAIL ADDRESS MYCHART DISCHARGE INSTRUCTIONS DECLINE

TEMPORARY ADDRESS (IF APPLICABLE)	CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY? YES NO UNKNOWN DECLINE	RACE	ADDITIONAL RACE	ETHNICITY

FURTHER DESCRIPTION OF ETHNICITY #1	FURTHER DESCRIPTION OF ETHNICITY #2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH VERY WELL WELL NOT WELL NOT AT ALL DECLINED UNAVAILABLE

WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?

WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? YES NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? YES NO

MARITAL STATUS	VISUALLY IMPAIRED? YES NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? YES NO	NOTIFY PCP OF RESULTS? ALL ABNORMAL NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION	FULL-TIME PART-TIME RETIRED STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code)	EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME CONTACT #1	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? YES NO	SUPPORT PERSON? YES NO

FULL NAME CONTACT #2	ADDRESS

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? YES NO	SUPPORT PERSON? YES NO

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PATIENT REGISTRATION DOWNTIME

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION		FULL-TIME PART-TIME RETIRED STUDENT	RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? YES NO	INJURED BODY PART: RIGHT LEFT	HOW DID INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)			CASE NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

WORKER'S COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)			CASE NUMBER

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	☐		Open Wounds/Ulcers	☐	
Arrhythmia (Irregular heartbeat)	☐		Osteoarthritis	☐	
Asthma	☐		Osteoporosis	☐	
Bleeding Problems	☐		Peripheral Vascular Disease	☐	
Blood Clots (DVT)	☐		Pneumonia	☐	
Cancer	☐		Psychiatric Illness (Depression)	☐	
Diabetes	☐		Pulmonary Embolus	☐	
Heart Attack	☐		Reflex Sympathetic Dystrophy	☐	
Heart Disease	☐		Reflux	☐	
High Blood Pressure	☐		Rheumatoid Arthritis	☐	
High Cholesterol	☐		Seizures	☐	
Infection	☐		Stroke	☐	
Kidney Disorders	☐		Ulcers	☐	
Lung Disease	☐		Other:	☐	

***For Females Only*: Do you think you may be pregnant at this time?** ☐ Yes ☐ No

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurence Date (approx.)	Any Complications?
1.		
2.		
3.		
4.		
5.		

Social History

Are you a tobacco user?	☐ Yes	☐ No
Do you consume alcohol?	☐ Yes	☐ No
If yes, how many drinks per week? ______		
Do you use any recreational drugs?	☐ Yes	☐ No
If yes, what kind(s): ______		

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
☐ Activity Change	☐ Ear pain	☐ Pain	☐ Shortness of breath
☐ Weight Change	☐ Nosebleeds		☐ Wheezing
☐ None	☐ None	☐ None	☐ None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
☐ Chest pain	☐ Blood in stool	☐ Excessive thirst	☐ Difficult urination
☐ Leg swelling	☐ Heartburn	☐ Excessive hunger	☐ Frequent urination
☐ Palpitations			
☐ Poor circulation			
☐ Pacemaker			
☐ None	☐ None	☐ None	☐ None

Skin	Neurological	Hematologic	Psychiatric
☐ Healing Problems	☐ Numbness	☐ Bruises	☐ Nervous/Anxious
☐ Wound	☐ Unsteady Walking	☐ Excessive Bleeding	☐ Depression
☐ None	☐ None	☐ None	☐ None

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PHARMACY INFORMATION

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions.

Please complete the information below:

Patient Name: ________________________________

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternative Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

LABORATORY INFORMATION

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to HSS laboratory.**

Laboratory	
LabCorp	
Quest Labs	
HSS Lab	
Other External Location	

Please provide name of external location: ________________________________

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A Message to Our Patients

We are required to collect race and ethnicity information on all patients. Racial and ethnic backgrounds may place people at different risks for certain diseases. By knowing more about your racial and ethnic background, we can better meet your health needs. Please review the selections on this card and select the ethnicity and race that best describes you.

	RACE DESCRIPTION	
	I	**AMERICAN INDIAN OR ALASKA NATIVE**
ASIAN (Please Select One From the Options Below)		
	AA	Asian Indian
	AB	Bangladeshi
	AC	Bhutanese
	AD	Burmese
	AE	Cambodian
	AF	Chinese
	AV	Taiwanese
	AG	Filipino
	AH	Hmong
	AI	Indonesian
	AK	Japanese
	AL	Korean
	AM	Laotian
	AO	Malaysian
	AR	Okinawan
	AZ	Pakistani
	AU	Sri lankan
	AW	Thai
	AX	Vietnamese
	AJ	Iwo Jiman
	AP	Maldivian
	AQ	Nepalese
	AT	Singaporean
	AN	Madagascar
	B	**BLACK OR AFRICAN-AMERICAN**
NATIVE HAWAIIAN OR PACIFIC ISLANDER (Please Select One From the Options Below)		
	PS	Polynesian
	PM	Native Hawaiian
	PU	Samoan
	PW	Tahitian
	PY	Tongan
	PX	Tokelauan
	PL	Micronesian
	PF	Guamanian or Chamorro
	PE	Guamanian
	PB	Chamorro
	PI	Mariana Islander
	PJ	Marshallese
	PP	Palauan
	PA	Carolinian
	PH	Kosraean
	PR	Pohnpeian
	PT	Saipanese
	PG	Kiribati
	PC	Chuukese
	PZ	Yapese
	PK	Melanesian
	PD	Fijian
	PQ	Papua New Guinean
	PV	Solomon Islander
	PN	New Hebrides
	PO	Other Pacific Islander
	W	**WHITE**
	O	**OTHER**
	U	**UNKNOWN**

	ETHNICITY DESCRIPTION	
SPANISH/HISPANIC ORIGIN (Please Select One From the Options Below)		
	37	Spaniard
	1	Andalusian
	3	Asturian
	8	Castillian
	9	Catalonian
	4	Belearic Islander
	20	Gallego
	40	Valencian
	7	Canarian
	38	Spanish Basque
	25	Mexican
	26	Mexican American
	28	Mexicano
	12	Chicano
	23	La Raza
	27	Mexican American Indian
	10	Central American
	15	Costa Rican
	21	Guatemalan
	22	Honduran
	29	Nicaraguan
	30	Panamanian
	34	Salvadoran
	11	Central American Indian
	6	Canal Zone
	35	South American
	2	Argentinean
	5	Bolivian
	13	Chilean
	14	Colombian
	19	Ecuadorian
	31	Paraguayan
	32	Peruvian
	39	Uruguayan
	41	Venezuelan
	36	South American Indian
	16	Criollo
	24	Latin American
	33	Puerto Rican
	17	Cuban
	18	Dominican
	N	**NOT HISPANIC OR LATINO**
	U	**UNKNOWN**