Santa Fe Hand Therapy, LLC
2009 Botulph Rd., Suite 200, SF, NM 87505 Ph:(505)986-2838 Fax:(505)986-2839

Patient Registration

PLEASE CLEARLY PRINT ALL INFORMATION

Last Name:

First Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: ( ) - Cell Phone: ( ) -

Work Phone: ( ) - Cell Phone: ( ) -

Emergency Contact: Relationship:

Emergency Contact Phone: Contact #1: ( ) - Contact #2: ( ) -

E-Mail Address:

Do we have permission to leave a message on your answering machine regarding appointments and test results? Yes ☐ No ☐ Via E-Mail Yes ☐ No ☐

Date of Birth: (MM/DD/YYYY) ____/____/____ Social Security Number: ____-____-____

Marital Status: Single ☐ Married ☐ Partnered ☐ Divorce ☐ Widowed ☐

Who is your referring Physician? Phone Number: ( ) -

Who is your Primary Care Physician? Phone Number: ( ) -

Employment Information

Who is your Employer?:

Employer's address: Employer Phone Number: ( ) -

Insurance / Billing Information

Is there any legal action pending that pertains to your visit or do you intend to see a lawyer at a later date regarding your issue? No □ Yes □ If yes please explain:

Who is your legal representation?: Phone Number: ( ) -

Is this a workman's compensation case? No ☐ Yes ☐ If yes please fill in the following:

Company Name: Claim #:

Adjuster Name: Adjuster Phone Number: ( ) -

Is this injury a result of a Motor Vehical Accident? No ☐ Yes ☐ If yes please fill in the following:

Insurance Carrier: Claim #:

Insurance Adjuster's Name: Adjuster Phone Number: ( ) -

*All Patients are required to present current insurance card(s) and photo ID. Please inform staff of secondary insurance coverage if you have it.

Primary Insurance Carrier: □ BC/BS □ UHC □ Presbyterian □Aetna □ Medicare □ Medicaid

☐ Lovelace ☐ Molina ☐ Other:

Subscribers Name:

Subscriber Date of Birth: (MM/DD/YYYY) ____/____/____

Subscriber Social Security #: ____-____-____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (Explain):

Insurance ID Number: Insurance Group Number:

Date: (MM/DD/YYYY) ____/____/____ Signature of Patient/Guardian:

PLEASE NOTIFY THE OFFICE STAFF IMMEDIATELY WHEN THERE ARE ANY CHANGES TO YOUR INSURANCE COVERAGE, IF YOU RECEIVE A NEW INSURANCE CARD OR YOU HAVE SOUGHT LEGAL REPRESENTATION FOR YOUR INJURY. NOT DOING SO MAY RESULT IN YOUR CLAIM(S) BEING DENIED AND YOU WILL BE HELD LIABLE FOR ALL COSTS INCURRED AS A RESULT. SANTA FE HAND THERAPY WILL NOT NEGOTIATE CLAIMS DENIED DUE TO PATIENTS NOT PROVIDING CORRECT OR UPDATED INFORMATION. PATIENT ACKNOWLEDGEMENT INITIALS ____

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Patient Consent

Please read the following document carefully.

Patient Name:_____DOB:_____

ASSIGNMENT OF BENEFITS – I hereby instruct my insurance carrier(s) to make payment as a direct assignment of my rights and benefits under my policy to Santa Fe Hand Therapy, LLC. I authorize the release of information pertinent to my insurance carriers(s.) A photocopy of this assignment and release shall be considered as effective and valid as the original.

FINANCIAL AGGREEMENT – I understand that I am responsible for all charges not paid by insurance company(s.) I further understand that payment, co-payment and deductibles for all office services are due at the time services are rendered. I request and authorize outpatient care as my Physician, their assistant or designee may deem necessary or advisable.

REFERALS – If my insurance company (including Medicaid) requires a prior referral, it is my responsibility to obtain this referral from my primary care Physician before visiting this facility. In the event that I choose to be seen without a referral, I understand that I will be responsible for service rendered.

DISCLOSURES –
All Patients:
I have received a copy of the Privacy Rules for this provider and authorize that the below person(s) may receive my protected Health Information. I may revoke this at any given time by giving written notification to this provider.

Medicare patients:
The products and /or services provided to you by (Santa Fe Hand Therapy, LLC) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c.) These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation.) The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

Authorized persons that may receive my Protected Health Information

_____

Printed name of patient or patient/guardian **Date**

_____

Signature of patient or patient/guardian **Date**

_____

Santa Fe Hand Therapy, LLC
Patient Medical History

Last Name:_____ **First Name:**_____ **Middle Initial:** _____**Age:**_____ **Date** ___/___/___

Chief Complaint

1. Reason for seeing Occupational Therapist today? _____

History of Present Illness

2. When did your problem, pain or injury begin?_____

3. How did your problem Start? (Please Check all that apply)
Suddenly☐ Slowly over time☐ During sports☐ At work☐ Fall☐ Lifting☐ Pulling☐ Auto accident☐ No cause☐

4. What are your symptoms?
Pain☐ Swelling☐ Redness☐ Bruising☐ Spasm☐ Numbness☐ Weakness☐ Tingling☐ Locking☐ Catching☐ Gives way☐

5. If you have pain, describe it. (Please check all that apply)
Constant☐ Intermittent☐ While at rest☐ At night☐ With Activity☐ Burning☐ Aching☐ Sharp☐ Dull☐

6. On average, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

7. What reduces your symptoms? (Please check all that apply)
Sitting☐ Lying down☐ Stopping activities☐ Standing☐ Walking☐ Medication☐ Occupational Therapy☐ Ice☐ Heat☐

8. What makes your problem worse? (Please check all that apply)
Sitting☐ Standing☐ Walking☐ Bending☐ Cough/Sneeze☐ Exercise (during)☐ Exercise (after)☐ Other☐

9. Have you had any diagnostic test for this problem?
X-Rays☐ CT scan☐ MRI☐ Injections☐ Arthogram (dye injection)☐ Electromyogram/nerve condition study☐

10. Were you seen in the emergency room for this problem? Y☐ N☐ Date ___/___/___

Review of Systems

11. Have you, the patient, ever been diagnosed with any of the following conditions? (Check all that apply)

- ☐ Vision or Hearing Problems
- ☐ Thyroid Problems
- ☐ Asthma or Emphysema
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Stomach Problems/Ulcers/Reflux
- ☐ Bowel or Bladder Problems
- ☐ Kidney Disease/Failure
- ☐ Diabetes
- ☐ Bone or Joint Problems
- ☐ Arthritis or Rheumatism
- ☐ Depression
- ☐ Gout
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Skin Disorders
- ☐ Seizures or Epilepsy
- ☐ Stroke
- ☐ Balance Problems
- ☐ Contagious Conditions
  - ☐ HIV
  - ☐ TB
  - ☐ Hepatitis
- ☐ None of the above

Past Medical History

12. Please list <u>ALL</u> previous surgeries, hospitalizations and / or broken bones.

a._____ date ___/___/___
b._____ date ___/___/___
c._____ date ___/___/___
d._____ date ___/___/___
e._____ date ___/___/___
f._____ date ___/___/___

Initial:_____ **Date** ___/___/___
Patient or Parent of minor

Santa Fe Hand Therapy , LLC

Past Medical History Con't

13. Please list **ALL** your current medications and their doses. Include "over the counter" meds and herbals.

Medication	Dose
a.	
b.	
c.	
d.	
e.	
f.	

14. Are you allergic to any medications? Y☐ N☐ Please list: _____

15. Women only: Are you, or could you be pregnant? Y☐ N☐ Due date: ___/___/___

Family History

16. Does any blood relative have a history of any of the following medical problems? (Check all that apply)

- ☐ Rheumatoid Arthritis/Osteoarthritis
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Heart Disease
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Problems with Anesthesia
- ☐ Stroke
- ☐ None of the above

Other (Please list) _____

Social History

17. What is your occupation? _____
18. What are your work and active living requirements? _____
19. Do/did you use tobacco? ☐Y ☐N How much? _____
20. Do you drink alcoholic beverages? ☐Y ☐N How many drinks per day? _____
21. Have you ever been addicted to prescription or non-prescription drugs? ☐Y ☐N Which? _____
22. Do you live alone? ☐Y ☐N
23. How often do you exercise? ☐Never ☐Rarely ☐Monthly ☐Weekly ☐Daily
    What type of exercise? _____
24. Which is your dominant hand? ☐Right ☐Left ☐Both

Miscellaneous

25. Is there any legal action pending that pertains to your visit? ☐Y ☐N If yes please describe. _____
26. What would you like to accomplish with Occupational Therapy?
    - ☐ Return to hobby/recreation/sport
    - ☐ Return to work
    - ☐ Improve strength and motion
    - ☐ Decrease pain
    - ☐ Improve daily function
    - ☐ Other: _____

Initial:_____ **Date** ___/___/___

Patient or Parent of minor

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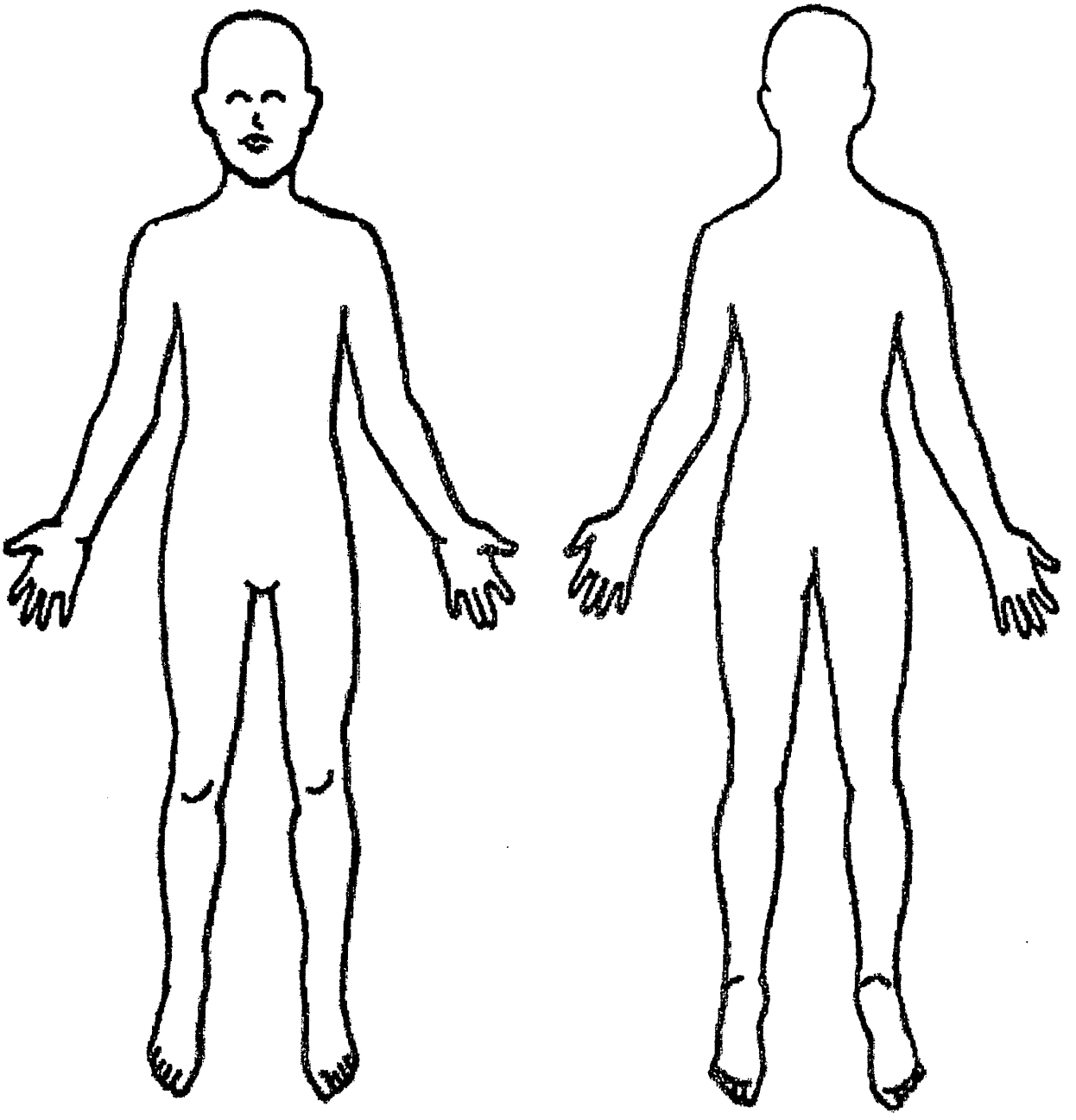
What is the date that you return to the Doctor? Date: ___/___/___

Please Shade the area(s) below where your symptoms are located. If you have pain, please write the intensity between 0-10 next to the shaded area. (0=No Pain, 5=Moderate Pain, 10=Severe Pain)



Signature:_____ **Date** ___/___/___

Patient or Parent of minor