Orthopedic Institute

Registration Forms

Before you get started

Gather the following information to complete your forms:

- Insurance card
- Medical records
- Medication names and doses
- Doctor information

Your accurate and complete medical history must be received before your visit to Orthopedic Institute, Inc to avoid appointment cancellations or delays.

Please complete all the forms in this packet.

Questions? Call your dedicated Patient Empowerment Consultant.

Personal information

Date:

Prefix: First name: MI: Last name: Suffix:

Date of birth: Age: Social Security #:

Driver's license #: Email:

Current mailing address:

City: State: ZIP code:

Home phone #: Cellphone #:

Secondary address :

City: State: ZIP code:

Sex: ◯ Male ◯ Female ◯ Undifferentiated ◯ Unknown

Marital status: ◯ Single ◯ Married ◯ Partnered ◯ Divorced ◯ Widowed

If you are married or otherwise partnered, what is the person's name?

Race: ◯ Black/African-American ◉ American Indian ◯ Asian
◯ White ◯ Hispanic or Latino ◯ Alaska Native
◯ Native Hawaiian/Pacific Islander ◯ Decline to answer ◯ Other

Ethnicity: ◯ Not Hispanic or Latino ◯ Hispanic or Latino ◯ None

Preferred language: ◯ English ◯ Spanish ◯ Decline to answer ◯ Other

Emergency contact information

I authorize Orthopedic Institute, PLLC to VERBALLY discuss my selected information with the following people, including translation from/to another language:

Contact name 1: Relationship:

Home phone #: Cellphone #:

Street address:

City: State: ZIP code:

Contact name 2: Relationship:

Home phone #: Cellphone #:

Street address:

City: State: ZIP code:

By selecting from the following options and signing, I authorize Orthopedic Institute, PLLC to discuss the following information with my emergency contact(s):

- ☐ My appointment information
- ☐ My billing and payment information
- ☐ My lab/test results
- ☐ My location within the facility
- ☐ My medical information (including symptoms, diagnosis, medication and treatment)

Cancellation of this authorization must be submitted in writing.

Signature needed

Patient/guardian signature:

Printed name: Date:

Insurance information

We **MUST** obtain this information to coordinate with your insurance company and provide the best care.

Primary insurance: Insurance company's phone #:
Policyholder's name (as on card): Policyholder's relationship:
Insurance claims address:
Policyholder's DOB: Policyholder's SSN:
Member ID/policy #: Group #:

Secondary insurance: Insurance company's phone #:
Policyholder's name (as on card): Policyholder's relationship:
Insurance claims address:
Policyholder's DOB: Policyholder's SSN:
Member ID/policy #: Group #:

Tertiary insurance: Insurance company's phone #:
Policyholder's name (as on card): Policyholder's relationship:
Insurance claims address:
Policyholder's DOB: Policyholder's SSN:
Member ID/policy #: Group #:

Attorney information

If your condition is the result of an accident or other injury for which you are represented by an attorney, please provide the following information about your attorney:

Name: Phone #:
Street address:
City: State: ZIP code:

Auto insurance

If your condition or injury is the result of an automobile accident, please provide the following information about the automobile insurance involved:

Company name: Claim #:
Phone #: Date of accident:
Name of policyholder: Relationship:
State accident occurred in: Adjuster name:

Have auto benefits been exhausted? ◯ Yes ◯ No
If yes, enter date benefits exhausted:

Workers' compensation

If applicable, please take a moment to provide the following information:

Company name: Claim #:
Phone #: Date of accident:
Name of insurance adjuster:

Patient history - Chief Complaint/Physician Information

Chief complaint

What is your primary concern?

How long have you had neck/back pain?

How did you hurt your neck/back?
(For auto accident or workers' compensation, please complete the necessary section on page 2.)

Does your pain interfere with your activities of daily living (self-care, meal prep, home maintenance)? ◯ Yes ◯ No
If yes, please explain:

Are you able to stand for long periods of time? ◯ Yes ◯ No

Are you able to sit for long periods of time? ◯ Yes ◯ No

Does your pain interfere with your daily job functions? ◯ Yes ◯ No

If yes, please explain:

Have you been diagnosed previously with a **spine condition** such as spinal stenosis, arthritis, scoliosis, herniated disc or fracture?

◯ Yes ◯ No

If yes, please explain:

Physician information

Primary care physician name: Phone #: Fax #:

Street address:

City: State: ZIP code:

Specialist name 1: Type: Phone #: Fax #:

Specialist name 2: Type: Phone #: Fax #:

Specialist name 3: Type: Phone #: Fax #:

Specialist name 4: Type: Phone #: Fax #:

Specialist name 5: Type: Phone #: Fax #:

By providing this information, you authorize Orthopedic Institute, PLLC to send a summary of your care and/or medical records to the providers listed above.

Patient history - Medical/Surgical

Medical history

Please indicate if you have any of the following and explain below:

- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Cholesterol disease
- ☐ Congestive heart failure
- ☐ Coronary heart disease
- ☐ Depression/anxiety
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gastrointestinal disease
- ☐ GERD
- ☐ Headaches/migraines
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart rhythm abnormalities
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney/bladder disease
- ☐ Liver disease
- ☐ MRSA
- ☐ Multiple sclerosis
- ☐ Nervous system disease
- ☐ Osteoporosis
- ☐ Pacemaker/defibrillator
- ☐ Prior infections
- ☐ Pulmonary (lung) disease
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Skin disorders
- ☐ Sleep apnea
- ☐ Strokes/TIA
- ☐ Tremors
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Vascular disease
- ☐ Other

If any of the above was checked, please explain:

Surgical history

Please indicate if you have had any of the following procedures, conditions or surgery on any of these areas:

- ☐ Abdominal
- ☐ Anesthesia complications
- ☐ Angioplasty/stents
- ☐ Ankle/knee/hip
- ☐ Appendix
- ☐ Arm
- ☐ Breast
- ☐ Chest/lung
- ☐ Coronary artery bypass
- ☐ Foot
- ☐ Gallbladder
- ☐ Hand
- ☐ Hernia
- ☐ History of dura leak
- ☐ Leg
- ☐ Low back/lumbar spine Mid
- ☐ back/thoracic spine
- ☐ Neck/cervical spine Nerve
- ☐ stimulator or pump
- ☐ Pacemaker/defibrillator
- ☐ Prostate
- ☐ Spine (neck/back)
- ☐ Thyroid
- ☐ Tonsil/wisdom teeth/adenoids
- ☐ Uterus/ovary
- ☐ Varicose veins
- ☐ Wrist/shoulder/elbow

If any surgery in the past year, or any spine surgery at any time, please explain:

Spinal surgical procedure #1

Surgeon name: _____ Phone #: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Surgery performed: _____

Date (MM/YY): _____ Level: _____ Outcome: _____

Spinal surgical procedure #2

Surgeon name: _____ Phone #: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Surgery performed: _____

Date (MM/YY): _____ Level: _____ Outcome: _____

Patient history - Medications/Allergies

Current Medications: Please clearly list below any prescription medications, over-the-counters and pain medications.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Med name 20mg	Twice a day	2-1-2025	Cholesterol

Supplements: Please clearly list below any herbs, vitamins or supplements.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Supplement name 20mg	Twice a day	2-1-2025	Immune support

Allergies: Please clearly list any allergies, medical or nonmedical.

Type of allergy	Reaction	Severity (please check one)			
		Mild	Moderate	Severe	Life threatening
Example: Penicillin	Hives, itching and rash		☑		
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Pain management care

Are you currently taking prescription pain medications? ◯ Yes ◯ No

Who prescribes your pain medication? ◯ Primary care physician ◯ Pain management physician ◯ Other

Physician name: _____ Phone #: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Fax#: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Do you have a pain management contract with your prescribing physician? ◯ Yes ◯ No

Is your prescribing physician aware that you are having surgery at Orthopedic Institute, PLLC? ◯ Yes ◯ No

Have you scheduled a follow-up appointment with your prescribing physician after your surgery? ◯ Yes ◯ No

Do you need assistance transitioning off of pain medication after your surgery? ◯ Yes ◯ No

Patient history - Conservative Care

Please bring all medical records for the treatment of your neck and back pain within the last 12 months.

Physical therapy

Provider name: Phone #:
Street address: City: State: ZIP code:
Percentage of relief: Start date (MM/YY): End date (MM/YY):
If unable to do or discontinued therapy before six to 12 weeks please explain why:

Pain management care

Provider name: Phone #:
Street address: City: State: ZIP code:
Percentage of relief: Start date (MM/YY): End date (MM/YY):

Injection/Procedure (steroid injection/ESI, radio frequency ablation/RFA)

Provider name: Phone #:
Street address: City: State: ZIP code:
Date of first injection (MM/YY): Percentage of relief:
Date of second injection (MM/YY): Percentage of relief:
Date of third injection (MM/YY): Percentage of relief:

Chiropractic care (traction, inversion, manipulation, decompression)

Percentage of relief: Start date (MM/YY): End date (MM/YY):

Massage

Percentage of relief: Start date (MM/YY): End date (MM/YY):

Home therapy - Heat/Ice

Percentage of relief: Start date (MM/YY): End date (MM/YY):

Acupuncture

Percentage of relief: Start date (MM/YY): End date (MM/YY):

Home exercise program

Percentage of relief: Start date (MM/YY): End date (MM/YY):

Over-the-counter pain medication (NSAIDs, Tylenol, topicals)

Percentage of relief: Start date (MM/YY): End date (MM/YY):

Prescription pain medication

Percentage of relief: Start date (MM/YY): End date (MM/YY):

Patient history - Family/Social

Family history Place a check by any family conditions and fill in the rest of the row.

Mother = **M**, Father = **F**, Sibling = **S**, Child = **C**, Maternal Grandparent = **MG**, Paternal Grandparent = **PG**

Condition (Please check)	Which family member?						Onset	Current family member condition
	M	F	S	C	MG	PG		
☐ Arthritis	☐	☐	☐	☐	☐	☐		
☐ Bleeding disorders	☐	☐	☐	☐	☐	☐		
☐ Cancer	☐	☐	☐	☐	☐	☐		
☐ Heart disease	☐	☐	☐	☐	☐	☐		
☐ Diabetes	☐	☐	☐	☐	☐	☐		
☐ Kidney/bladder disease	☐	☐	☐	☐	☐	☐		
☐ Liver disease	☐	☐	☐	☐	☐	☐		
☐ Neuromuscular disease	☐	☐	☐	☐	☐	☐		
☐ Osteoporosis	☐	☐	☐	☐	☐	☐		
☐ Pulmonary disease	☐	☐	☐	☐	☐	☐		
☐ Stroke	☐	☐	☐	☐	☐	☐		
☐ Thyroid disease	☐	☐	☐	☐	☐	☐		
☐ Malignant hyperthermia	☐	☐	☐	☐	☐	☐		

Social history

Have you ever used any form of nicotine or tobacco? ◯ Yes ◯ No

If so, have you received counseling to stop tobacco use? ◯ Yes ◯ No

Type of tobacco	Daily amount	Years used	Age started	Date ended
Cigarettes				
Cigar				
Pipe				
E-cigarette				
Chewing/smokeless/snuff				
Nicotine patch				

Do you drink coffee, tea or soda? ◯ Yes ◯ No

If you answered yes: How many cups per day? _____ Per week? _____

Do you drink alcohol? ◯ Yes ◯ No

If you answered yes: How many drinks per day? _____ Per week? _____

Please sign and date upon completion of registration forms below:

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Medication hold list (Please keep a copy for your reference.)

Please review and sign to acknowledge that you understand the following Medication Hold List.

If you are taking an over the counter medication not listed here and you are unsure of its actions, please consult your pharmacist or physician, or call Orthopedic Institute, PLLC at 888-990-0077, from Monday through Friday, 8 a.m. to 7 p.m. Pacific Standard Time.

The following medications **MUST BE STOPPED FIVE DAYS** prior to your surgery.

- Advil
- Aggrenox
- Aleve
- Alka-Seltzer
- Amigesic
- Anacin products
- Anaflex
- Anaprox
- Ansaid
- Apo-ASEN
- Arco Pain Tablet
- Argeric
- Arthropan
- Arthrotec
- Ascriptin
- Aspergum
- Aspirin (all products containing aspirin)
- Aspir-Low
- Aspirtab
- Bayer
- Bayer time release
- Buffex
- Bufferin
- Bufferin Arthritis
- Buffinol
- Butalbital Compound
- Butazolidin
- Cama Arthritis
- Carisoprodol
- Compound
- Cataflam
- Clinoril
- Combunox
- Cope
- Daypro
- Diclofenac
- Diflunisal
- Disalcid
- Doan's
- Dolobid
- Easprin
- Ecotrin 81
- Empirin
- Endodan
- Entrophen
- Equagesic
- Es Anacin
- Etodolac
- Excedrin Migraine
- Feldene
- Fenoprofen
- Fiorinal
- Flector Patch
- Floctafenine
- Flurbiprofen
- Glucosamine
- Goody's
- Halfprin
- Helidac
- Ibuprofen
- Indocin
- Indomethacin
- Instantine
- Kaopectate
- Kava
- Ketoprofen
- Ketorolac
- Lodine
- Lovaza
- Magan
- Magnaprin
- Marthritic
- Meclofenamate
- Meclomen
- Medipren
- Mefenamic acid
- Midol
- Mobic
- Mobiflex
- Momentum
- Mono-Gesic
- Motrin
- Nabumetone
- Nalfon
- Naprelan
- Naprosyn
- Naproxen
- Norgesic Forte
- Nuprin
- Ocuvite
- Oruvail
- Orudis
- Oxaprozin
- Pamperin-IB
- Pepto-Bismol
- Percodan
- Phenylbutazone
- Piroxicam
- PMS-ASA
- Ponstel
- Prevacid NapraPAC
- Relafen
- Robaxisal
- Roxiprin
- Salflex
- Salsalate
- Sine-Aid IB
- Sodium salicylate
- Soma Compound
- St. Joseph Aspirin
- Sulindac
- Suprofen
- Suprol
- Surgam
- Synalgos-DC
- Tandearil
- Talwin Compound
- Tenoxicam
- Tiaprofenic acid
- Tolectin
- Tolmetin
- Toradol
- Tricosal
- Trilisate
- Vanquish
- Vicoprofen
- Voltaren
- Zorprin

We recommend you stop taking the following supplements at least five days prior to your scheduled surgery: St. John's wort, garlic, ginger, ginkgo biloba, ephedra (ma huang) and vitamin E.

By signing, I agree that I must not take any of these over-the-counter medications for the time frame specified. I understand that failure to follow these instructions might result in the postponement of my surgery.

Signature needed

Patient/guardian signature: _____

Printed name: _____ Date: _____

Medication alert list (Please keep a copy for your reference.)

Continue these prescribed blood-thinning medications **unless** Orthopedic Institute, PLLC has been provided with **written approval/permission** from your doctor that you can stop the medication. If you are on any of these prescribed medications, speak to your Care Team nurse.

If you are diabetic: Consult with the doctor who treats your diabetes about your insulin dosage or other diabetic medication. You may experience an elevation in your blood sugar before, during and/or after surgery due to the stress of surgery and the steroid medications used during the surgery. Please have a plan to address this with your local doctor who treats your diabetes so you are ready to handle elevations in your blood sugar while you are at Orthopedic Institute, Inc. This could include additional checking of your blood sugar and additional insulin as needed. Our providers will check and treat your blood sugar before, during and after surgery. For your safety, we ask that you follow your regular doctor's instructions after you are released from Orthopedic Institute, PLLC Please closely monitor your dietary intake to prevent blood sugar fluctuations.

Orthopedic Institute, PLLC will inform you of the exact date of your surgery. Medication instructions will be given after we are able to obtain written permission from your prescribing physician.

Please take time to review and sign to acknowledge that you understand the following Medication Alert List.

WARNING:

THESE MEDICATIONS CAN ONLY BE STOPPED WITH APPROVAL OF YOUR PRESCRIBING PHYSICIAN.

- Aggrenox (aspirin/dipyridamole)
- Arixtra (fondaparinux)
- Aspirin (when prescribed by your physician)
- Brilinta (ticagrelor)
- Coumadin (warfarin)
- Eliquis (apixaban)
- Fragmin (dalteparin)
- Innohep (tinzaparin)
- Lovenox (enoxaparin)
- Plavix (clopidogrel)
- Pletal (cilostazol)
- Pradaxa (dabigatran etexilate)
- Xarelto (rivaroxaban)

By signing, I understand that approval must be obtained from my prescribing physician before stopping any of these medications prior to my surgery date. **I understand that failure to follow the exact instructions regarding what day to take the last dose of these medications might result in postponement of my surgery.**

Signature needed

Patient/guardian signature: _____

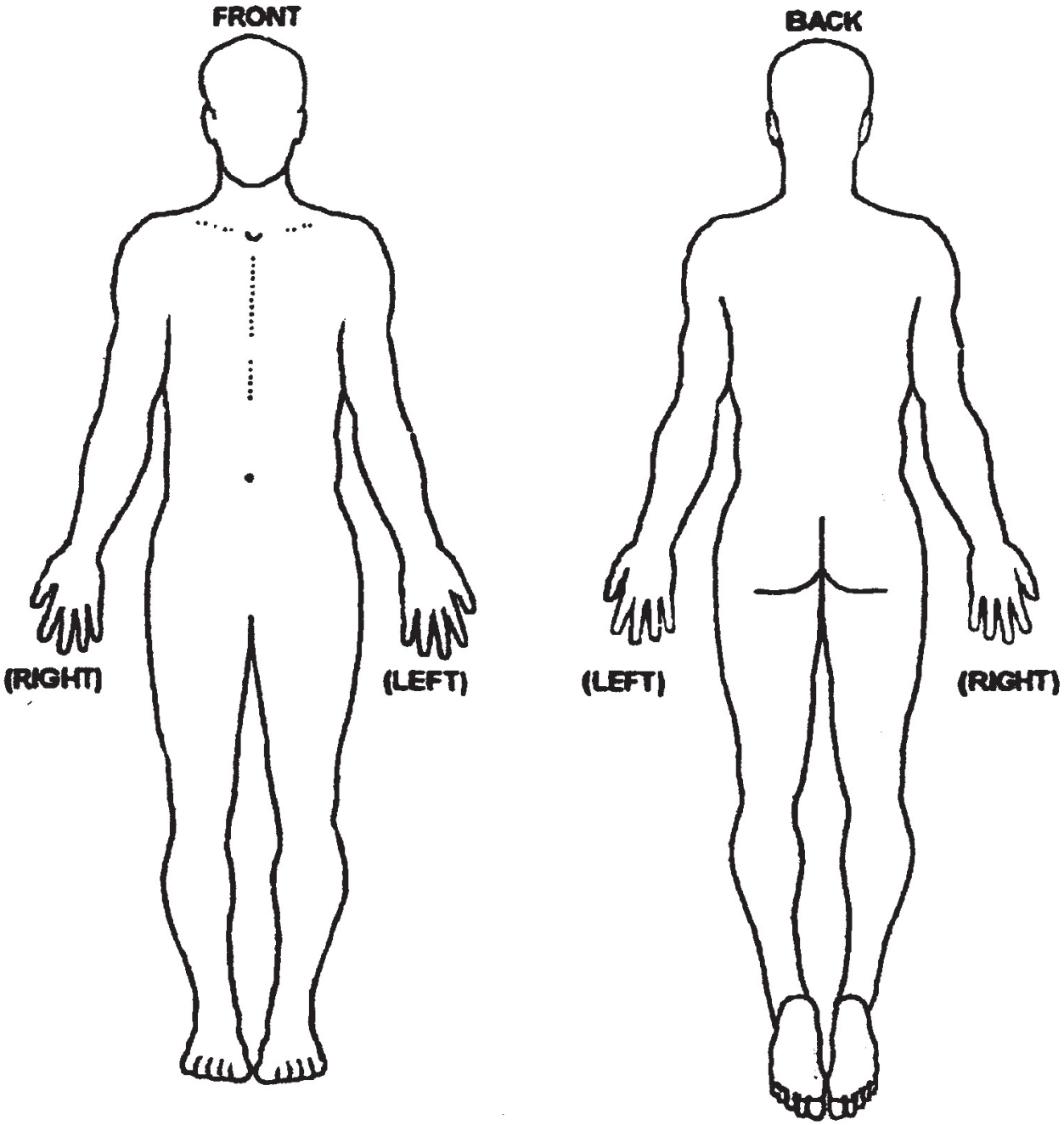
Printed name: _____ Date: _____

Pain Drawing

Patient Name: _____

Please indicate where you are having symptoms by using the proper symbols and arrows to show where the pain goes or shoots. Be sure to show all areas involved and to indicate where the pain is the worst.

Aching / Pain (XXXX)
Numbness / Tingling (OOOO)
Pins / Needles (: : : :)
Burning (////)
Spasm / Cramp (△△△△)



Phone: 888-990-0077 FAX: 480-546-6989
www.OrthopedicInstitute.com

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS PHYSICIAN-PATIENT ARBITRATION AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS PHYSICIAN-PATIENT ARBITRATION AGREEMENT.

By: _____

Physician or Duly Authorized Representative Signature (Date)

By: _____

Print or Stamp Name of Physician, Medical Group or Association Name

By: _____

Signature of Translator (if applicable) (Date)

_____

Print Name of Translator

By: _____

Patient's Signature (Date)

By: _____

Print Patient's Name

By: _____

Patient's Representative's Signature (Date)

_____

Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

CONSENT FORM

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment. I authorize Orthoped Institute, PLLC and its providers and such physicians, associates, assistants, and other personnel or the hospital or medical facility chosen by him or her to perform the practice of medicine with the intention to improve my general well-being as discussed with me. At the time of treatment, I understand I can authorize any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the recommended procedure.

GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described to me in discussion with my provider. These risks include, yet are not limited to, the risk of bleeding, infection, pain, injury to neurovascular structures which control sensation, motor function and viability to the procedural region as well as anesthesia risks and death.

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this procedure or treatment as described to me in discussion with my provider.

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks as described to me in discussion with my provider.

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered. I also understand no treatment is always an option if I do not want to take the above discussed procedural/treatment risks.

SECOND OPINION: I understand I can be offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT: I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue, hardware or member in accordance with customary hospital or medical facility practice.

PHOTOGRAPHY: I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use.

NO GUARANTEES: I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

FINANCIAL POLICY: I understand that even if I have insurance, I may incur charges that are my responsibility. I understand that it is my responsibility to know my benefits and deductible information and whether or not the (PROCEDURE, DME PRODUCT, INJECTION) I am about to have is covered. If my deductible has not been met, or my insurance carrier denies this procedure, I understand that the financial responsibility is mine and that this office will bill me for services not covered or paid for by my insurance. If you are insured with a plan we are NOT contracted with, you are required to pay for the visits in full, at the time of service.

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read this form thoroughly.

DATE:_____ PRINT PATIENT NAME:_____ SIGNATURE:_____

(Patient, Parent, or Legal Guardian)