St. Clair Health
St. Clair Medical Group

Today's Date: ___________

New Patient Registration Form

Patient Demographic Information

Full Legal Name: ____
Last | First | Middle

Date of Birth: ____________________ MM / DD / YYYY

Sex: ☐ Male ☐ Female ☐ Other ____________________ *Please Specify*

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Please Address As: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Race/Ethnicity: ☐ AmerIndian/Alaskan ☐ Asian ☐ Black/AfricanAmer ☐ Hawaii/PacificIsland ☐ Hispanic/Latino ☐ Not Disclosed ☐ Unknown ☐ White

Address: ____
STREET | APT #

____
CITY | STATE | ZIP CODE

Phone Number: ____
Please circle preferred: HOME | CELL | WORK

Email Address: ____

Employment: ☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Student Full-Time ☐ Student Part-Time

Employer: ______________________________ **Occupation:** ______________________________

Emergency Contact: ____
Name | Relation | Phone Number

If Minor, Parent / Guardian: ____
Name | Relation | Phone Number

Primary Insurance	Secondary Insurance (If applicable)
Insurance Company: ______________________	**Insurance Company:** ______________________
Policy Holder Name ______________________	Policy Holder Name ______________________
ID# ____________ Group # ____________	ID# ____________ Group # ____________
Address ______________________	Address ______________________
Phone # ______________________	Phone # ______________________
DOB ____________ SS# [optional]____________	DOB ____________ SS# [optional]____________
Relationship to Patient ______________________	Relationship to Patient ______________________

Workers Compensation/Auto (if applicable)

Name of Insurance Company ______________________ Phone # ______________ Fax # ______________

Claim # ______________________ Date of Injury ______________ SS# [optional]______________

Billing Address ____

Adjuster Name ______________________ Phone # ______________________

Employer Contact ______________________ Phone # ______________________

St. Clair Health

St. Clair Medical Group

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other heal th plan benefits to the St. Clair Medical Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE: I request that Medicare benefits be made on my behalf to St. Clair Medical Group for healthcare services furnished. I authorize any holder of medical information about me to release to HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information needed to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

____ Signature of Patient or if a minor, Responsible Party

______________________________ Date

St. Clair Health

St. Clair Medical Group

St. Clair Medical Group Policies & HIPAA

*Welcome to **St. Clair Medical Group** and thank you for choosing us as your healthcare provider. We would like to take this opportunity to advise you of our practice policies. These policies help us to provide quality care in an efficient manner. Please do not hesitate to contact our office manager if you have any questions about these policies.*

NOTICE OF PRIVACY PRACTICES

We value our patients' rights to privacy in regard to their health information. Please take a moment to review our Notice of Privacy, which provides a complete description of permitted uses and disclosures of healthcare information.

DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I wish to allow disclosure to the following family members, friends, or individuals. I understand that I may change this list at any time:

NAME	RELATIONSHIP	PHONE NUMBER	DISCLOSURE	LIMITATIONS
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	

In the event that we need to contact you, are we permitted to leave a message on your answering machine? ☐ **Yes** ☐ **No**

In case of an emergency, may we contact an individual listed above *(marked as "full" disclosure)?* ☐ **Yes** ☐ **No**

ST. CLAIR MEDICAL GROUP POLICIES

- You are responsible for notifying us of any changes to your address, personal information, or insurance information.
- **St. Clair Medical Group** is pleased to process your insurance claim for reimbursement. However, please remember that:
  - You must present your insurance card and photo ID at each visit.
  - Your insurance is a contract between you, your employer, and the insurance company. **St Clair Medical Group** is not a party to your health insurance contract.
  - Not all services are covered benefits on all insurance contracts. Some insurance companies have certain services that they will not cover.
- All copayments are to be paid in full at the time of service.
- If you do not have health insurance coverage or do not bring proof of health insurance coverage to each visit, payment in full will be due at the time of your visit.
- We accept payments in the form of cash, personal check, and most major credit cards. However, we **do not accept Care Credit.** If you are in need of financial assistance, please review St. Clair Medical Group policy on https://www.stclair.org/billing-insurance/financial-assistance/
- **St. Clair Medical Group** and/or agencies working on St Clair Medical Service's behalf may need to contact patient or guarantor via land phone line or cell phone regarding balance due for services.
- Out of consideration to our other patients, if you arrive more than 15 minutes late to your appointment, there may be a delay in your visit, or you may be asked to reschedule your appointment.
- Please understand that our appointment times are limited. If you are unable to keep your scheduled appointment please notify us at least **24 hours in advance** to reschedule.
- **St. Clair Medical Group** requests previous medical records so that we may have the best understanding of your medical history.

PATIENT ACKNOWLEDGEMENT

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the Notice of Privacy Practices.

______________________________ ______________________________ ______________

Patient Name (PRINTED) **Signature of Patient or Responsible Party, if a Minor** **Date**

****FOR OFFICE USE ONLY****
A good faith effort was used to obtain written acknowledgement of the Notice of Privacy Practices on:
Office Staff Name (PRINTED):______________________ Office Staff Signature ______________________ Date:__________

St. Clair Health
St. Clair Medical Group

Referring Physician: ____________________

Primary Care Physician: ____________________

May we send your physician(s) a report of this visit? ☐ Yes ☐ No

Your Current Problem:

Please describe the problem that brings you into the office today: ____________________

____

Describe the symptoms and area affected (type of pain, swelling, numbness, etc.) ____________________

____

When did this problem begin (date of injury)? ____________________

If you had an injury, how did it happen? ____________________

Is this a work related problem? ☐ Yes ☐ No If disabled, when did you last work ____________________

Is there an attorney involved with your case? ☐ Yes ☐ No If yes, who: ____________________

Social History:

What is your work status? ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ Homemaker

What is your occupation? ____________________

What level of activity is required in your workplace:

☐ Mild-desk job ☐ Moderate-standing, lifting ☐ Extensive-manual labor

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Do you have any children? ☐ Yes ☐ No If so, how many children? ____________________

Who lives at home with you? ____________________

Do you use tobacco? ☐ Yes ☐ No Did you previously use tobacco? ☐ Yes ☐ No

☐ Cigarettes____pack/day ☐ Pipe ☐ Cigar ☐ Chewing tobacco For how many years? ____________________

Do you use alcohol? ☐ Yes ☐ No If yes, # of drinks___Daily ______Weekly_________Monthly

Do you use any street drugs? ☐ Yes ☐ No If yes, describe: ____________________

Do you have any history of drug or alcohol abuse? ☐ Yes ☐ No If yes, describe: ____________________

Past Medical History:

Please check boxes of any past medical problems that you have had.

- ☐ None
- ☐ Lung Disease
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Ulcers
- ☐ Gastric Reflux/GERD
- ☐ Liver Disease
- ☐ Hepatitis A/ B/ C
- ☐ Alcoholism
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blood Clots (DVT)
- ☐ Bleeding Tendencies
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular Disease
- ☐ Kidney Disease
- ☐ Depression
- ☐ Cancer
- ☐ Heart Disease
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fractures
- ☐ Thyroid Disease
- ☐ Immune Disorder
- ☐ Seizure Disorders
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Mental Illness
- ☐ None
- ☐ Other ______________________

Past Surgical History:

Please list any operations that you have had in your lifetime.

Year	Type of Operation

Medications:

Please list all medications including over the counter medicines, herbals and prescription medications that you take.

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

Allergies:

Please list all medications and substances that you are allergic to.

Medication allergy	What reaction did you have?
☐ None	
☐ Penicillin	
☐ Sulfa	
☐ Iodine	
☐ Latex	
☐ Contrast dyes	
☐ Adhesive tape	
☐ Other (please specify)	

Family History:

Please check illnesses that have occurred in any of your blood relatives.

☐ Diabetes
☐ Lung Disease
☐ Tuberculosis (TB)
☐ Asthma
☐ Alcoholism
☐ Ulcers
☐ Hepatitis A/ B/ C/
☐ Gastrointestinal Disease
☐ Heart Disease
☐ High Blood Pressure
☐ Stroke
☐ Heart Attack
☐ Blood Clots (DVT)
☐ Bleeding Tendencies
☐ Coronary Artery Disease
☐ Peripheral Vascular Disease
☐ Cancer
☐ Arthritis
☐ Osteoporosis
☐ Seizure
☐ Depression
☐ Mental Illness
☐ Thyroid Disease
☐ Kidney Disease
☐ Other ______________________________

Relation	Alive/Deceased	Age	Health Status/Cause of Death
Mother			
Father			
Sibling			
Sibling			
Sibling			

Review of Systems/Current Symptoms: **Height:**______________ **Weight:**______________

Are you currently having or have you recently had any of the following problems? (**Please circle**)

Constitutional

Recent weight loss	Yes	No
Recent fevers or chills	Yes	No
Night sweats	Yes	No
Difficulty sleeping	Yes	No

Ears, Nose , Throat

Hearing loss	Yes	No
Ringing in ears	Yes	No
Sinus problems	Yes	No
Sore throat	Yes	No
Active dental issues	Yes	No
Wear hearing aid or dentures	Yes	No

Cardiovascular

Irregular heart beat	Yes	No
Chest pain, angina	Yes	No
Bleeding problems	Yes	No
Blood clots	Yes	No
Swelling arms or legs	Yes	No

Respiratory

Shortness of breath	Yes	No
Cough	Yes	No
Breathing difficulties	Yes	No

Gastrointestinal

Heartburn	Yes	No
Nausea and /or vomiting	Yes	No
Changes in bowel habits	Yes	No
Blood in bowel movements	Yes	No

Musculoskeletal

Joint pain	Yes	No
Limb pain	Yes	No
Muscle weakness	Yes	No
Difficulty moving arm /leg	Yes	No
Swelling limb/joint	Yes	No

Eyes

Wear glasses or contacts	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Vision problems	Yes	No

Skin

Psoriasis or eczema	Yes	No
Open sores or cuts	Yes	No
Dermatitis - rash	Yes	No

Neurologic

Headaches	Yes	No
Dizziness	Yes	No
Falls	Yes	No
Memory problems	Yes	No
Balance problems	Yes	No
Numbness/tingling	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disorder	Yes	No

Cancer Yes No

What kind? ____

Genitourinary

Frequent bladder infections	Yes	No
Painful urination	Yes	No
Difficulty starting urination	Yes	No
Blood in urine	Yes	No

Mental Health

Depression	Yes	No
Anxiety	Yes	No

Other

List:____

Patient signature:____Date:______________

Reviewed by:____Date:__________Time:__________

St. Clair Health
St. Clair Medical Group

Today's Date: ______________

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of your protected health information, as set forth below, consistent with Federal law concerning the privacy of such information. **Both sides must be completed and signature is REQUIRED. Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: ______________________________ **Date of Birth:** ______________
(LAST) (FIRST) (M.I.)

Address: ______________________________
STREET APT #
____
CITY STATE ZIP CODE

Phone Number: ______________________________
Please circle preferred: HOME CELL WORK

Use and Disclosure of Protected Health Information

St. Clair Medical Group Orthopedic Surgery is authorized to (circle one): **SEND** *OR* **RECEIVE**
Practice Address: **1000 Bower Hill Rd. Suite 7300, Pittsburgh, PA 15243**
Phone Number: **412-942-7262** *Fax Number:* **412-942-7397**

______________________________ is authorized to (circle one): **SEND** *OR* **RECEIVE**
(PERSON(S) / ORGANIZATION(S))

Practice Address: ______________________________
(STREET) (SUITE #) (CITY) (STATE) (ZIP CODE)

Phone Number: ______________________ *Fax Number:* ______________________

My health information will be used for the following purpose(s): ______________________________

This Authorization applies to the following information (select all applicable):

❑ **ALL** health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: ______________________________

OR

❑ **ONLY** the following records or types of health information:

❑ Inpatient ❑ Outpatient ❑ TCC ❑ IRU
❑ Discharge Summary ❑ Imaging Reports ❑ PT/OT/Speech/Audiology

Treatment Dates: ______________________________

❑ History & Physical ❑ Laboratory Reports ❑ Operative Reports ❑ Emergency Department Record
❑ Consultations ❑ Transfer Abstract ❑ Transfer Abstract ❑ Pathology Reports
❑ Surgical Slides and/or Tissue

❑ Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions
❑ HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, and Sexual preference/contacts
❑ Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services
❑ Specific Exclusions: ______________________________

NOTE: If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed. This information has been disclosed to you from records protected by Pennsylvania Law.

NOTE: If this Authorization is for marketing purposes, please note the following: The organization authorized to use or disclose my protected health information ❑ will or ❑ will not receive direct or indirect compensation for the use or disclosure of my information.

Expiration of Use and Disclosure of Protected Health Information

This Authorization expires **[insert date or event]** if less than ninety days:____

Patient Rights Regarding Protected Health Information

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address: **St. Clair Medical Group Orthopedic Surgery: 1000 Bower Hill Road, Suite 7300, Pittsburgh, PA 15243**

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I understand that a fee may be assessed to process this request.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

Patient / Patient Representative Signature

Date: ____________________________ **Time:** ___________________________________ AM / PM

Signature: ____
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: _________________________________

❑ ***Verbal response given (patient physically unable to give written consent)***

A verbal consent requires two (2) witness signatures. I witness that the patient (or responsible party) is definitely unable to provide a signature at this time but understands the nature of the release and freely gives his/her consent.

____ _______/_______/________
Witness Date

____ _______/_______/________
Witness Date