Welcome to Ocean Orthopedic Associates, PA

New Patient Registration Form

Instructions: *Please complete both sides. Print clearly, fill in all relevant information and sign on back.*

PATIENT REGISTRATION INFORMATION

Patient's Full Name: _____

❒ Female ❒ Single
❒ Male ❒ Married
❒ Widowed
❒ Separated
❒ Divorced
❒ Left Handed
❒ Right Handed

Date of Birth: (*per Social Security*) Mo: _____ Day: _____ Year: _____ Age: _____

Social Security Number: _____

Address: Street: _____

City: _____ State: _____ Zip: _____

Ethnicity: _____

Preferred Language spoken?
❒ English
❒ Spanish (Espanol)
❒ French (Français)
❒ German (Deutsch)
Other _____

Home Phone No.: (_____) _____ Cell No.: (_____) _____ Work/Alternate No./Ext. (_____) _____
Area Code Area Code Area Code

Your Email: _____

Spouse/Significant Other's Name: _____

Veteran? ❒ yes ❒ no

Do you have an Advanced Directive? ❒ Yes ❒ No ***If yes, please provide a signed copy of the directive***

Person to call in an emergency: _____ Telephone No.: (_____) _____
Area Code

Responsible Party (for minor patient) _____

Current Employer: _____ Phone: _____

Name of Family/Primary Care Physician: _____

Were you referred to us by another ❒ Physician ❒ Person ❒ Patient? If so Name: _____

TODAY'S VISIT

REASON FOR TODAY'S VISIT: _____

What Conditions or Symptoms are you experiencing? *Please describe pain below* Side of Body - ❒ Left ❒ Right

_____

_____

_____

_____

_____

_____

_____

_____

When did symptoms appear or date of injury _____

_____

Were you in an auto accident? ❑ Yes ❑ No Is this employment or work related? ❑ Yes ❑ No

Was Symptom a result of an accident or fall? ❑ Yes ❑ NO

REV 06/18

PLEASE COMPLETE OTHER SIDE ➔

PATIENT MEDICAL INFORMATION

Do You: (Please Check Yes or No)

Yes	No		
❒	❒	Drink Coffee.....	How Often? _____
❒	❒	Use Tobacco Products.....	How Often? _____
❒	❒	Drink Alcoholic Beverages.....	How Often? _____
❒	❒	Exercise.....	How Often? _____
❒	❒	Current Weight _____ lbs. - Variation - (+ or -) _____lbs.	
❒	❒	Current Height _____ - Variation - (+ or -) _____inches	

FAMILY HISTORY

Please complete as much as possible relating to your Family History

Relation	*Deceased or Living*	*Age now or when Deceased*	*Medical Condition or Cause of Death*
Father			
Mother			
Other Significant:			

PAST MEDICAL HISTORY

MEDICAL CONDITIONS - Please list ❒ Cancer ❒ High Blood Pressure ❒ Diabetic ❒ High Cholesterol ❒ Thyroid

PAST SURGICAL HISTORY Please list Date or approximate Age when occurred

LIST PREVIOUS FRACTURES - List bone(s) and approximate year fracture occurred

ALLERGIES - Please list all Allergies including Drug Allergies / Food Allergies

PHARMACY NAME:

PHARMACY ADDRESS: PHARMACY PHONE No.:

MEDICATIONS - Please list ALL medicine/drugs patient is currently taking, or present a list of your medications.

Medicine / Drug Name	Dose or Amount	Frequency (daily, weekly)

Signature of Patient: _____ Date: _____

I hereby certify that the information disclosed herein is true and accurate to the best of my knowledge and that no material falsification or misrepresentation has been made.