PATIENT REGISTRATION

Chitranjan Ranawat | Amar Ranawat | Anil Ranawat

Last Name ______________________________First Name_________________ Date _______________

Address ____

City ____________________________________ State ____________ Zip _______________

Sex M F Date of Birth _________________ SS # ________-_______-________

Home Phone ____________________ Work _____________________ Cell _____________________

Occupation ____ presently working ______ Yes ________NO

Email ____

May we contact you via email regarding:
Your Appointment, Billing, Research Y_____ N______

Is your current problem related to
a claim for worker's compensation or a current or potential lawsuit? Y_____ N______

Emergency Contact

Name_____________________Phone ______________________ Relationship______________________

Primary Care Physician

Name ____________________Phone ____________________ Fax number__________________________

Address__________________________________ City______ State____ Zip Code___________

Referring Physician

Name ____________________Phone ____________________ Fax number__________________________

Address__________________________________ City______ State____ Zip Code___________

Primary Insurance Information

Please present your insurance card to the front desk staff.

Primary Insurance Carrier ____

Policy # ________________________________ Group # _____________________

Name of Insured _____________________________

Secondary Insurance (Circle One)

Medicare, Private Insurance, Workmen's Compensation NO Fault

Insurance Carrier ____

Policy # ________________________________ Group # _____________________

WCB# (worker's Comp) _______________________ Date of Accident ________________

PATIENT REGISTRATION

Chitranjan Ranawat | Amar Ranawat | Anil Ranawat

Assignment and Release

I, the undersigned, have insurance coverage with ______________________________ and assign all medical benefits to: Ranawat Orthopaedics or Anil Ranawat. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian ____________________________________ Date _______________

REFERRAL

I realize that my particular insurance plan might require a referral for me to be seen by any of the physicians employed by Ranawat Orthopaedics or Anil Ranawat.If at any time I fail to obtain a referral for a particular visit, I will be responsible for obtaining a valid referral from my primary care physician (PCP). If a valid referral is not possible, I will be solely responsible for all charges.

Signature of Insured/Guardian ____________________________________ Date _______________

HIPAA Privacy Practices Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that Ranawat Orthopaedics, PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of Insured/Guardian ____________________________________ Date _______________

RANAWAT ORTHOPAEDICS

ROC Medical Profile

HOSPITAL FOR SPECIAL SURGERY

Name: ______________________________

Current Medications:

Medications	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Medical History: Please **circle** appropriate response(s) and **write in answer where appropriate**

General Health: Excellent Good Fair Poor

Head: Headaches History of Injury Other (Please Describe): ______________________

Neck: Any Issues (Please Describe): ______________________

Skin: Any Issues (Please Describe): ______________________

Eyes: Loss of Vision Glasses Cataract Other (Please Describe): ________________

Ears: Hearing Loss Other (Please Describe): ______________________

Nose/Throat: Bleeding Sinus Trouble Other (Please Describe): ______________________

Respiratory: Asthma Other (Please Describe): ______________________

Heart: Chest Pain Heart Disease Irregular Heartbeat High Blood Pressure Other__

Bleeding: Any Issues (Please Describe): ______________________

Metabolic: Diabetes Hypothyroid Other (Please Describe): ______________________

Stomach/Bowel: Constipation Nausea/Vomiting Bleeding Other (Please Describe): ___________

Urinary: Leakage Discharge/Drainage Other (Please Describe): ____________________

Neurological: Headaches Seizures(epilepsy) Stroke Numbness Other: _________________

Prior Diseases: Hepatitis AIDS Herpes Infection Involving Joint Other: ________________

Prior Surgeries: Thyroid Surgery Heart Bypass Appendectomy Back Surgery Arthroscopy Other___

Allergies: Penicillin Food (list): Other: ________________________

Do you Smoke? Yes No If yes, number of packs per day? Number of years?______________

Do you Drink? Yes No If yes, number of drinks per week? Number of years?_____________

Current Height: ______________________________ **Current Weight:** ______________________________

Name:____________________________ Date:____________

WOMAC

	None	Mild	Moderate	Severe	Extreme
1. How much pain do you have walking on a flat surface:	☐	☐	☐	☐	☐
2. How much pain do you have going up or down stairs:	☐	☐	☐	☐	☐
3. How much pain do you have at night while in bed?	☐	☐	☐	☐	☐
4. How much pain do you have sitting or lying?	☐	☐	☐	☐	☐
5. How much pain do you have standing upright?	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Extreme
6. How severe is your stiffness after first wakening in the morning?	☐	☐	☐	☐	☐
7. How severe is your stiffness after sitting, lying or resting later in the day?	☐	☐	☐	☐	☐

What degree of difficulty do you have with:	None	Mild	Moderate	Severe	Extreme
8. Descending Stairs?	☐	☐	☐	☐	☐
9. Ascending Stairs?	☐	☐	☐	☐	☐
10. Rising from sitting?	☐	☐	☐	☐	☐
11. Standing?	☐	☐	☐	☐	☐
12. Bending to the floor?	☐	☐	☐	☐	☐
13. Walking on a flat surface?	☐	☐	☐	☐	☐
14. Getting in/out of the car?	☐	☐	☐	☐	☐
15. Going Shopping?	☐	☐	☐	☐	☐
16. Putting on socks/stockings?	☐	☐	☐	☐	☐
17. Rising from bed?	☐	☐	☐	☐	☐
18. Taking off socks/stockings?	☐	☐	☐	☐	☐
19. Lying in bed?	☐	☐	☐	☐	☐
20. Getting in/out of bath?	☐	☐	☐	☐	☐
21. Sitting?	☐	☐	☐	☐	☐
22. Getting on/off toilet?	☐	☐	☐	☐	☐
23. Heavy domestic duties?	☐	☐	☐	☐	☐
24. Light domestic duties?	☐	☐	☐	☐	☐

PATIENT ASSESSMENT QUESTIONAIRE **HIP**

Name: ______________________________ Date: ______________________________

1. Have you had pain recently (within the last 3 months) on the affected hip? (Please circle responses)

Right Side:	**Yes / No**						
If yes,	**location:**	Buttock	Groin	Thigh	Side	Lower Back	Knee
	Severity:	None	Mild	Moderate		Severe	Excruciating
	Frequency:	Never	Rarely	Occasionally		Frequently	Always
Left Side:	**Yes / No**						
If yes,	**location:**	Buttock	Groin	Thigh	Side	Lower Back	Knee
	Severity:	None	Mild	Moderate		Severe	Excruciating
	Frequency:	Never	Rarely	Occasionally		Frequently	Always

2. Do you limp? Never Rarely Occasionally Frequently Always
If yes, because of your: right hip / left hip / both hips

3. Do you have difficulty with:

a. putting on socks/shoes?	None	Slight	Moderate	Great	Unable
b. personal care (toilet, bathing, etc)	None	Slight	Moderate	Great	Unable
c. household activities (cleaning, etc)	None	Slight	Moderate	Great	Unable
d. getting in and out of a car?	None	Slight	Moderate	Great	Unable

4. How much assistance do you need with going up and down stairs?

None cane/crutch/banister 2 crutches walker/someone's assistance Unable

5. How far can you walk? (before your pain limits you)

Unlimited 10+ blocks 4-10 blocks 1-3 blocks Housebound

6. Please select your favorite recreational activities and how often you would participate in them:

a. Walking (>1 mile)	Never	Rarely	Occasionally	Frequently	Always
b. Running	Never	Rarely	Occasionally	Frequently	Always
c. Swimming	Never	Rarely	Occasionally	Frequently	Always
d. Gym Workout	Never	Rarely	Occasionally	Frequently	Always
e. Tennis	Never	Rarely	Occasionally	Frequently	Always
f. Golf	Never	Rarely	Occasionally	Frequently	Always
g. Gardening	Never	Rarely	Occasionally	Frequently	Always
h. Other:____________	Never	Rarely	Occasionally	Frequently	Always

How often does your affected hip influence or prohibit the performance of these activities?

Never Rarely Occasionally Frequently Always

7. How often does your affected hip influence your social activities? (recreation, traveling)

Never Rarely Occasionally Frequently Always

8. How often does your hip pain influence your sense of well being? (emotionally, mentally)

Never Rarely Occasionally Frequently Always

9. Please rate your degree of satisfaction with your ability to use your hip.

Unsatisfied 0 1 2 3 4 5 6 7 8 9 10 Fully Satisfied