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 _____

Medical Profile

RANAWAT ORTHOPAEDICS

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 — KNEE

Name: _____ Date: _____ **(Please circle responses)**

1. Have you had pain recently (within the last 3 months) on the affected knee?

Right Knee:	**Yes / No**					
If yes,	**location:**	Inner	Outer	Front	Back	Allover
	Severity:	None	Mild	Moderate	Severe	Excruciating
	Frequency:	Never	Rarely	Occasionally	Frequently	Always
Left Knee:	**Yes / No**					
If yes,	**location:**	Inner	Outer	Front	Back	Allover
	Severity:	None	Mild	Moderate	Severe	Excruciating
	Frequency:	Never	Rarely	Occasionally	Frequently	Always

2. Do you hear any noises coming from your knee? No Right knee Left knee Both knees
If yes, is it associated with pain? Yes / No

3. Do you limp? Never Rarely Occasionally Frequently Always
If yes, because of your? right knee / left knee / both knees

4. 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
e. kneeling?	None	Slight	Moderate	Great	Unable
f. squatting?	None	Slight	Moderate	Great	Unable
g. sitting on your heels?	None	Slight	Moderate	Great	Unable

5. How much assistance do you need with going up and down stairs?
None cane/crutch/banister 2 crutches walker/someone's assistance Unable

6. How far can you walk?
Unlimited 10+ blocks 4-10 blocks 1-3 blocks Housebound

7. 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 knee influence or prohibit the performance of these activities?
Never Rarely Occasionally Frequently Always

8. How often does your affected knee influence your social activities?
Never Rarely Occasionally Frequently Always

9. How often does your knee pain influence your sense of well being?
Never Rarely Occasionally Frequently Always

10. Please Rate your degree of satisfaction with your ability to use your knee.

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