DESERT HAND ASSOCIATES
SURGERY OF THE HAND AND UPPER EXTREMITY
ERIC L. FREEDMAN, M.D.

Patient Registration Form

Date: _____

Patient name (please print) _____
Patient's address: _____
Street City State Zip code
DOB: _____ Sex: Male / Female _____

Home phone: ( ) _____ Cell phone: ( ) _____
Email: _____

Marital status: Single Married Widowed Divorced Separated _____

Occupation: _____ Employer: _____
Employer phone: _____

Spouse's name: _____ Phone: _____
(can we share your health information with this person?) Y or N

If patient is a minor, responsible adult: _____
Relation? _____ phone: _____

Emergency contact: _____ relation: _____
Phone: _____ (can we share your info with this person?) Y or N

Primary policy holder name: _____
relation: _____ DOB: _____

I hereby authorize Eric L. Freedman, M.D. to furnish the above insurance company all information which said insurance company may request concerning my illness or injury. I hereby assign to Eric L. Freedman M.D. all payments to which I am entitled for medical and/or surgical expense relative to the services reported for the above. I understand I am financially responsible to said doctors for my portion of allowed charges, charges applied to my deductible or charges not covered by my policy. If monthly payments become past due, I agree to pay the total amount owing upon demand and to pay reasonable service charges, collection cost, attorney fees, and court cost as permitted by law. I understand I will be charged a $15.00 service fee for any returned checks.

_____ _____
Date Patient or legal guardian

760 342.8444 • fax 760 342.8544

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General Health Questionnaire

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Handedness: Right or Left

List current treating physicians: _____

Pharmacy info: _____

Reason for todays visit and brief history on how it began:

_____

_____

Do you have any **drug** allergies?: Y / N If yes, what are they?:

_____

List **all** current medications (include herbs/supplements/vitamins):

1. 5.
2. 6.
3. 7.
4. 8.

Do you have any medical problems/health conditions such as: (circle)
Heart problems/diabetes/elevated cholesterol/high blood pressure/AIDS/HIV+
Other: _____

List previous surgeries and approximate dates:

_____

_____

Family History? (Circle all that apply): Diabetes / cancer / leukemia / tuberculosis / heart trouble/high blood pressure/stroke/anemia/bleeding tendency/kidneydisease/other_____

Social History

How many children do you have? _____
Are you employed? Y / N FT or PT Did you retire? Y / N when?_____
Are you disabled? Y / N Do you drink alcohol? Y / N Quanity? _____
Are you a smoker? Y / N How long? _____ Packs per day: _____
Former smoker? Y / N How long ago? _____

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Review of systems

Do you or have you ever had any of the following problems?:

Skin:	
Sores that do not heal?	Y / N
Change in skin moles?	Y / N
Head:	
Recent severe headaches?	Y / N
Blackout or fainting spells?	Y / N
Convulsions or epilepsy?	Y / N
Eye, Ear, Nose, and Throat:	
Difficulty or pain with swallowing?	Y / N
Trouble with balance?	Y / N
Heart and Lungs:	
Emphysema?	Y / N
Chest pain or discomfort?	Y / N
Leg cramps at night?	Y / N
Tuberculosis?	Y / N
Coughing up of blood?	Y / N
Heart attack or coronary problems?	Y / N
Blood clots?	Y / N
Abnormal EKG?	Y / N
Heart murmur?	Y / N
Inflamed veins (thombophlebitis)?	Y / N
Stomach and bowels:	
Bloody or black bowel movements?	Y / N
Frequent loose stool or diarrhea?	Y / N
Stomach, duodenal or peptic ulcer?	Y / N
Hepatitis or cirrhosis?	Y / N
Glands:	
Sugar diabetes?	Y / N
A thyroid disorder?	Y / N
Other glandular problems?	Y / N
Blood:	
Swollen glands in armpits, neck or groin?	Y / N
Excessive bleeding with operations?	Y / N
A diagnosis of anemia?	Y / N
Muscles and Bone:	
Arthritis?	Y / N
A bone infection (osteomyelitis)?	Y / N
Gout?	Y / N
Nervous System:	
Ever had a stroke or paralysis?	Y / N
Been treated for emotional problems?	Y / N

Do you have any other problems that have not already been mentioned? If so, please specify:_____

FOR OFFICE USE ONLY

Eric L. Freedman, M.D. Date

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

EMAIL, X-RAY CONSENT

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

- **How this office will use and disclose your protected health information.**
- **Your privacy rights regarding your protected health information.**
- **This office's obligations concerning the use and disclosure of your protected health information.**

EMAIL CONSENT

- **Email communication with Desert Hand Associates is provided as a convenience to the patient; however, by your continued communication via email with Desert Hand Associates, you consent to email communication and are accepting the inherent insecurity and the privacy risks therein.**

X-RAY CONSENT – FEMALE PATIENTS

- **If you are pregnant or think you possibly may be, please inform us prior to your x-ray examination.**

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ _____

Patient or Patient Representative Signature Date

_____

Patient or Patient Representative Printed Name