



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

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General Health Questionnaire

Name: _____ Date: _____

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

List current treating physicians: _____

Pharmacy info: _____

Reason for today's 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 Quantity? _____

Are you a smoker? Y / N How long? _____ Packs per day: _____

Former smoker? Y / N How long ago? _____



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 (thrombophlebitis)? _____

_____ 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

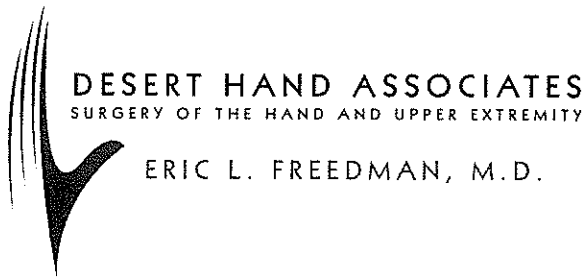
Been treated for emotional problems? _____

_____ 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



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