WELLSPAN HEALTH

WellSpan Health

Permission to Release Diagnostic/Medical Information to Another Individual

Effective Date:* _____

Print Patient's Full Name: _____

Patient's Date of Birth: _____ MR#: _____

I give WellSpan Health entities permission to release diagnostic test results to, and discuss protected health information with, the following person(s):

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

I give WellSpan Health entities permission to leave any protected health information on an answering machine or voicemail.

❑ **Yes** ❑ **No**

I give WellSpan Health entities permission to mail any office correspondence to the address I have provided _____
Initials

Indicate your relationship to the patient: ❑ **Patient** ❑ **Patient Representative**

_____
Print Name ***(if other than patient)***

_____
Signature **Date**

***This form is good for 1 year unless otherwise specified. If applicable, please specify alternate date:_____.**

Hanover Orthopaedics
WellSpan

PATIENT HISTORY FORM

207 Blooming Grove Road • Hanover, PA 17331-7917
717.632.5259 • 1.800.451.9383
717.637.6356 (Acct. Info.)

Name: _____ **Date of Birth:** _____

Chief Complaint

Why are you seeing the doctor today? _____

Medication/Strength	How Often Taken	Reason for Medication

ALLERGIES:

Is Tetanus up-to-date? ❑ Yes ❑ No

Review of Systems

Are you currently having or have you had problems with any of the following?

	Circle	If Yes, Describe		Circle	If Yes, Describe
Eyes	Yes No		Arthritis	Yes No	
Ears, Nose, Throat	Yes No		Numbness/Tingling	Yes No	
Lungs, Breathing	Yes No		Neck	Yes No	
Digestion	Yes No		Shoulder	Yes No	
Bladder Problem	Yes No		Low Back	Yes No	
Diabetes	Yes No		Hip/Thigh	Yes No	
High Blood Pressure	Yes No		Knee/Leg	Yes No	
Bleeding Problems	Yes No		Leg	Yes No	
Balance Problems	Yes No		Ankle	Yes No	
Blackout/Fainting	Yes No		Foot	Yes No	
Psychological Problems	Yes No		Other (Specify)	Yes No	
AIDS/HIV	Yes No		**Xrays Performed**	Yes No	
Cancer	Yes No		**MRI Performed**	Yes No	
Polio	Yes No		**CT Scan Performed**	Yes No	
TB	Yes No		**Nerve Conduction Studies**	Yes No	
Epilepsy	Yes No		**Where Performed**		
Cardiac	Yes No				

Please turn over to complete second side of Patient History Form.

		Date			Date			Date
❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____
❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____
❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____
❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____
❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____	❑ No Changes	❑ Updated	_____

Continued on Back

Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? ❑ No ❑ Yes

If yes, did you have any problems with anesthesia? ❑ No ❑ Yes If yes, explain: _____

Family History

Please complete information regarding Father/Mother

Father	Mother
Alive Deceased Age:	Alive Deceased Age:
Major Health Problems:	Major Health Problems:

Social History

❑ Work in the home ❑ Employed (Occupation _____) ❑ Student ❑ Day Care ❑ Retired

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Children? ❑ No ❑ Yes # _____

Do you live alone? ❑ No ❑ Yes

History of substance abuse? ❑ No ❑ Yes What? _____

Smoke currently? ❑ No ❑ Yes # of packs per day _____ for _____ years

Quit smoking? ❑ This year ❑ Less than 1 year ❑ 2-5 years ❑ 6-10 years ❑ More than 10 years

Previously smoked? _____ packs per day for _____ years

Drink alcohol? ❑ Daily ❑ 1-2 times per week ❑ 1-2 times per month ❑ 1-2 times per year ❑ None

Patient/Guardian Signature: _____ Date: _____

Staff Review: _____ Date: _____

Hanover Orthopaedics
WellSpan

PATIENT REGISTRATION - UNDER AGE 18

(Please Print)

REFERRED BY _____ TODAY'S DATE _____

PATIENT'S NAME _____
First Middle Initial Last Nickname

ADDRESS _____

PHONE (____)_____ DATE OF BIRTH _____ SS # _____

FATHER: NAME _____ DATE OF BIRTH _____ SS # _____

HOME ADDRESS _____ PHONE (____)_____

EMPLOYER _____ PHONE (____)_____

EMPLOYER'S ADDRESS _____

MOTHER: NAME _____ DATE OF BIRTH _____ SS # _____

HOME ADDRESS _____ PHONE (____)_____

EMPLOYER _____ PHONE (____)_____

EMPLOYER'S ADDRESS _____

FAMILY PHYSICIAN _____ ADDRESS _____

HAVE YOU EVER USED ALCOHOL? ❑ Yes ❑ No HAVE YOU EVER USED ILLEGAL DRUGS? ❑ Yes ❑ No

HAVE YOU EVER USED TOBACCO PRODUCTS? ❑ Yes ❑ No

IN CASE OF EMERGENCY

CLOSEST RELATIVE, FRIEND, OR NEIGHBOR _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

REPORT OF VISIT: It is our policy to furnish one report of a visit to the referring or family physician. To whom do you wish us to send reports?

_____

The policy in our office is: The parent who requests treatment for the child is responsible for all fees for the services rendered. Payment is due at the time of treatment unless other arrangements have been made in advance with the doctor or secretaries.

Signature of parent requesting treatment _____ Date (today) _____

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services to include those your insurance considers non-covered.

Signature of patient, parent, or
responsible party (Circle relationship) _____ Date (today) _____

If you have any questions regarding the completion of this form, please bring the form along with your insurance cards to the front desk and we will be pleased to assist you.

INSURANCE SIGNATURE ON FILE

PATIENT'S NAME _____ DOB#_____

INSURANCE COVERAGE

I request that payment of authorized Commercial Benefits, Medicare or Secondary Medicare coverage benefits be made directly to the WellSpan Medical Group for any services furnished to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

_____ _____

Primary Identification Number Secondary Identification Number

_____ _____

Primary Insurance Secondary Insurance

_____ _____

Date Signature of Patient (or Parent, if patient is a minor)

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