Patient Registration Form: Hand & Arm Center

MASSACHUSETTS GENERAL HOSPITAL
ORTHOPAEDICS

Tell us about yourself

Name: _____ DOB: _____ MGH Medical Record #: _____

Date of Injury: _____ Height: _____ Weight: _____

Workers Comp? ☐ Yes ☐ No Claim # & Case Manager: _____

Best way to contact you? ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Phone #: _____ Best time to call: _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Present Medical History: Hand Service

Occupation: _____ ☐ Part-time ☐ Full-time ☐ Retired ☐ Not working ☐ SSDI

Which is your dominant hand? ☐ Left ☐ Right Which hand do you want checked? ☐ Left ☐ Right

What is the *main* problem? ☐ Pain ☐ Numbness ☐ Other: _____

Has a doctor given a diagnosis? ☐ No ☐ Yes, what? _____

What do you think caused your problem? On what date? _____

Past History: *If your doctor is NOT at Mass General, please provide the following information:*

List any medical problems (i.e. asthma, high blood pressure), prior illness or injuries: _____

_____

List allergies & reactions to medications: _____

Latex allergy: ☐ No ☐ Yes Other allergies (to food, pollen, etc): _____

_____

Ever had problems with anesthesia? ☐ No ☐ Yes, please explain: _____

Had post-operative nausea/vomiting? ☐ No ☐ Yes Have you been exposed to: ☐ Hepatitis ☐ AIDS

Current Medications

_____

_____

_____

_____

_____

Prior Surgeries

_____

_____

_____

_____

_____

Please contact MassGeneral Registration Referral Center at 1-866-211-6588 and update your demographic and insurance information. I hereby authorize my insurance benefits to be paid directly to Massachusetts General Physician Organization (MGPO) and acknowledge that I am responsible for any balance not covered by those benefits. I authorize MGPO to release information requested concerning my care to insurers paying such benefits.

To the best of my knowledge, my answers are correct

_____

Sign your name Today's date

Supplementary Page: If you need more space to fill in answers from the previous page, use the space below.

Name: _____ MGH Medical Record #: _____

Medications (Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other over-the-counter medications. Include vitamin, mineral, and herb supplements.)

Current Medication(s)	Dose	Frequency

Surgical / Hospitalization History

Year	Surgeries / Hospitalizations	Complications

Additional Information

_____

_____

_____

_____

_____

To the best of my knowledge, my answers are correct

_____

Sign your name Today's Date