SOUTHERN JOINT REPLACEMENT INSTITUTE

2400 Patterson Street, Ste 100
Nashville, TN 37203
615-342-0038
Fax: 615-329-4469

Office Hours: Mon-Fri 8am-430pm

Welcome to our practice!

Thank you for choosing our practice for your orthopedic care. The staff at Southern Joint Replacement Institute would like to make your experience with our office a pleasurable one.

In order to better serve you, we ask our patients to **arrive at least 30 minutes prior to your scheduled appointment to allow time for parking, X-rays and to obtain any additional medical information, if needed**. **Please consider utilizing the free Valet parking at the front of our building, Physician' Park.**

In addition, we strongly encourage you to complete these online New Patient Registration Forms and bring them to your appointment along with:

- Current Insurance Card(s)
- Drivers' License or Photo ID
- Name, Address and Phone Numbers of your Primary Care Physician and any other Specialists you have recently seen
- List of Current Medications

If your insurance requires a referral and/or authorization, please contact your PCP prior to the scheduled visit to obtain the referral and/or authorization. This can be faxed to our billing office at 615-329-4469. If the referral and/or authorization are not received prior to your appointment, you may be asked to reschedule.

Payments of co-pays, deductibles and other out of pocket expenses are to be paid at time of service. For your convenience, we accept cash, checks, Visa, MasterCard, and American Express.

Please feel free to contact our office at 615-342-0038 or 1-877-442-SJRI (toll-free) if any additional information is needed or if you are unable to keep your scheduled appointment.

Thank you for selecting our practice! We look forward to serving you!

Physicians and Staff of Southern Joint Replacement Institute

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM ____/DD ____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ___-___-___ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM ____/DD ____/YYYY _____

Social Security Number ___-___-___ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY ____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY ____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

SJRI Medical History Form

DATE: _____ NAME: _____ AGE: _____

HEIGHT: _____ WEIGHT: _____ REASON FOR VISIT _____

Do you smoke? □ Yes □ No If yes, how many packs per day? _____ Have you ever smoked? □ Yes □ No

If yes, when did you quit? _____ Do you use alcohol? □ Yes □ No If yes, how many drinks per week? _____

Do you or have you used the following in the last 3 months? □ Marijuana □ Cocaine □ Heroin □ Crack □ Methamphetamine

Current Meds	Dosage

Are you allergic to any medications? ____Yes ___No

Allergen	Reaction

Previous Surgery	Date

Have you or family member ever had any of the following?

	Who?	When?
□ Asthma		
□ Stomach Problems		
□ Bladder Problems		
□ Jaundice/Liver		
□ Alcoholism		
□ Kidney Disease		
□ Prostate		
□ Skin Disease		
□ Joint Disease		
□ Gout		
□ Stroke		
□ Other _____		

	Who?	When?
□ Epilepsy/Seizures		
□ Depression/Anxiety		
□ Thyroid		
□ High blood pressure		
□ Blood clot		
□ Tuberculosis		
□ Diabetes		
□ Gout		
□ Psychiatric Disorder		
□ Cancer		
□ Lung Disease		
□ Heart Disease		

Southern Joint Replacement Institute-Authorization to Treat

Authorization of Treatment: I, the undersigned, hereby consent to the performance of treatment(s) considered medically necessary or advisable based on the judgment of my physician. ***Minors:** Medical care or immunizations cannot be given unless my child is accompanied by one of the following:

_____

_____

I fully understand that this consent is given in advance of any specific diagnosis or treatment and will remain in full force until revoked in writing. I understand that Southern Joint Replacement Institute may include consent at other satellite offices under common ownership.

Patient Financial Responsibility: I understand my financial responsibility and I guarantee payment for all charges not covered by my insurance, all applied deductibles and co-pays, within 45 days of receiving a statement.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or responsible party) Signature Date

_____

Relationship

SOUTHERN
JOINT
REPLACEMENT
INSTITUTE

Michael J. Christie, M.D.
J. Craig Morrison, M.D.
David K. DeBoer, M.D.
Jeffrey T. Hodrick, M.D.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PRIMARY CARE PHYSICIAN INFORMATION

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

We value your feedback and would like to know how you heard about Southern Joint Replacement Institute:

- ☐ SJRI Website
- ☐ Family/Friend
- ☐ Internet Search
- ☐ Former or Current Patient/Please provide name: _____
- ☐ Primary Care Physician/Name: _____
- ☐ Specialist Physician/Name: _____
- ☐ Other Healthcare Facility/Please specify: _____
- ☐ Insurance Network/Please specify: _____
- ☐ Other/Specify: _____