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*** __________________

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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: ______________________