

Patient Registration Form

Please Complete Both Sides Entirely

www.orthoneuro.com

Today's Date: _____

Last Name: _____		First Name: _____		M.I.: _____	
Address: _____		City: _____		State: _____ Zip: _____	
Home Phone: (____) _____ - _____		Cell Phone: (____) _____ - _____		Other: (____) _____ - _____	
Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other _____
Are you employed? <input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____
Employer: _____		Employer Phone: (____) _____ - _____			
Are you a student? <input type="checkbox"/> Yes		<input type="checkbox"/> No	Name of School: _____		
Spouse's Name: _____		SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Emergency Contact: _____		Phone: (____) _____ - _____		Relation to Patient: _____	

If the patient is a minor under age 18, please list the responsible party.

Last Name: _____		First Name: _____		Relation to Patient: _____	
Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Address: _____		City: _____		State: _____ Zip: _____	
Home Phone: (____) _____ - _____		Cell Phone: (____) _____ - _____		Other: (____) _____ - _____	
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other _____
Are you employed? <input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____
Employer: _____		Employer Phone: (____) _____ - _____			

Medical Insurance Information

Primary Insurance Company: _____		Phone: (____) _____ - _____			
Claims Address: _____		City: _____		State: _____ Zip: _____	
Subscriber ID / Policy Number: _____		Group Number: _____			
Name of Insured: _____		Insured DOB: ____/____/____			
Insured's SS#: _____ - _____ - _____		Insured Employer: _____			

Secondary Insurance Company: _____		Phone: (____) _____ - _____			
Claims Address: _____		City: _____		State: _____ Zip: _____	
Subscriber ID / Policy Number: _____		Group Number: _____			
Name of Insured: _____		Insured DOB: ____/____/____			
Insured's SS#: _____ - _____ - _____		Insured Employer: _____			

For Workers' Compensation Claims – Please complete the following:

Employer at time of injury: _____ Date of injury: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Name of Workers' Comp Insurance Co: _____ CLAIM #: _____
Contact Person: _____ Phone: (_____) _____-_____
Doctor of record for this claim: _____

For Auto, or "Other" Insurance Claims – Please complete the following:

Date of Accident or Injury: _____ CLAIM #: _____
Auto or "Other" Insurance Company: _____ Phone: (_____) _____-_____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Phone: (_____) _____-_____

Is the patient allergic to any medications? Yes No If yes, please list: _____

How did you hear about us?

Yellow Pages Friend / Family Member / Patient
 Internet Website Advertisement
 Physician (please complete below) Other _____
Referred By: _____ Phone: (_____) _____-_____
Do you have a Primary Care Physician (PCP)? Yes No
Primary Care Physician: _____ Phone: (_____) _____-_____

If you have any questions, or are not sure how to answer any of these questions, please do not hesitate to ask for help.

Is this visit related to an accident or injury? Yes No
Is this visit related to an accident, injury or otherwise, related to your workplace? Yes No
Is this visit related to an accident or injury at a school event? Yes No
Is this visit related to an auto accident or injury? Yes No
Is this visit related to an accident or injury other than auto, employment, or school event? Yes No
If yes, please describe: _____

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to OrthoNeuro Consultants. I authorize OrthoNeuro Consultants to release any information, acquired in the course of my treatment, needed for my medical insurance claim(s). A photocopy of this authorization is to be considered valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I understand that I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. I understand that copays are expected at the time services are rendered.

I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Please Answer All Questions To Assist Us In Caring For You

Name _____ Date of Birth ___/___/___ Age ___ Height ___ Weight ___

Occupation _____ Sex _____ What side did you injure? RIGHT LEFT BOTH

- What did you injure? _____ Date of injury or when symptoms started _____
- Is this a work related problem or injury for which a claim is being filed? YES NO (must answer)
- Do you use tobacco products? YES NO If yes, what and how much? _____
- Please list any medical problems you have. Examples: heart or lung disease, cancer, diabetes, hepatitis, HIV, anemia, stroke, blood clots, thyroid disease, high blood pressure...

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Please list any past surgeries you've had and the year occurred.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Please list all medications you are taking and the dosage.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Please list any allergies you have including medications.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do any close relatives have similar medical problems? What relative has what problem?

Are you presently experiencing any of these general medial symptoms? Circle all that apply.

Fever	Headache	Nausea	Chest Pain
Chills	Ringin g in Ears	Vomiting	Shortness of Breath
Rash	Blurred Vision	Constipation	Abdominal Pain
Fatigue	Fainting	Diarrhea	Urinary Problems
Other _____			

In relation to today's problem, do you have any of these symptoms? Circle all that apply.

Pain	Instability	Cracking Noises	Numbness
Swelling	Giving Way	Cracking Feelings	Tingling
Locking	Weakness	Redness or Warmth	Pain at night

What makes your problem worse? _____

What makes your problem better? _____

Is there anything else you would like us to know about your problem? _____

I certify that the above information is fact and authorize OrthoNeuro to provide this information to my insurance company to assist in processing my medical claim in a timely manner.

Signature _____ Date _____

OTHER MEDICAL PROBLEMS

- | | |
|-----------------------------|--|
| _____ Heart disease | _____ Sinusitis |
| _____ Cancer | _____ Ear infection |
| _____ Lung disease | _____ Bronchitis/ asthma |
| _____ Cholesterol | _____ Arthritis (osteo/rheumatoid) |
| _____ Ulcer/stomach disease | _____ Dental disease |
| _____ Stroke | _____ Anemia |
| _____ Diabetes | _____ Skin disorder |
| _____ Hypoglycemia | _____ Sleep disorder |
| _____ High blood pressure | _____ Sore throat/ tonsillitis |
| _____ Brain tumor | _____ Seizure/ epilepsy |
| _____ Mononucleosis | _____ Glaucoma |
| _____ Encephalitis | _____ Lumps/ cysts |
| _____ Meningitis | _____ Deep vein thrombosis/ thrombophlebitis |
| _____ Headaches | _____ Bleeding disorder |
| _____ Thyroid problems | _____ Tuberculosis |
| _____ Snoring | _____ Hepatitis A or B/ liver disease |
| _____ Panic attacks | _____ Aneurysm |
| _____ Mental illness | _____ Kidney disease |
| _____ Depression | _____ Other (explain _____) |

D) Check any that apply

_____ single _____ married _____ divorced _____ widowed

Children's names and ages

How much do you smoke per day? _____

How many years have you smoked? _____

Do you use smokeless tobacco? yes _____ no _____

Please indicate how much alcohol you consume

_____ beers per week

_____ glasses of wine per week

_____ ounces(drinks) of liquor per week

Have you in the past or do you use recreational drugs? _____yes

_____no

Last year of school completed _____

What is your support system? _____

**PATIENT ACKNOWLEDGMENT FORM
NOTICE OF PRIVACY PRACTICES**

Patient Name: _____ Date: _____

- I have received a copy of OrthoNeuro's Notice of Privacy Practices.
- I was offered a copy of OrthoNeuro's Notice of Privacy Practices but declined it.

Patient Signature: _____

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- A good faith effort was made to provide a copy of OrthoNeuro's Notice of Privacy Practices to this patient and to obtain his/her acknowledgement of the same. Patient accepted
- declined the Notice and refused to sign this acknowledgement for the following reason:

OrthoNeuro Representative: _____

Signature: _____

Date: _____