Ortho**Neuro**

Spine***Med*** • Sport***Med*** • Work***Med***

A Multi-Specialty Center of Excellence

Patient Registration Form

Please Complete Both Sides Entirely

Today's Date: ___________________

www.orthoneuro.com

Last Name: ____________________ First Name: ____________________ M.I.: ______

Address: ____________________ City: ____________ State: ______ Zip: _________

Home Phone: (_______)________–__________ Cell Phone: (_______)_________–___________ Other: (_______)________–____________

Sex: ☐ Male ☐ Female SS#: ___________–__________–______________ Date of Birth: _______/________/_________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ____________________

Are you employed? ☐ Yes ☐ No ☐ Disabled ☐ Retired ☐ Other ____________________

Employer: ______________________________ Employer Phone: (_______)_______–_________

Are you a student? ☐ Yes ☐ No Name of School: ______________________________

Spouse's Name: ____________________ SS#: ________–________–____________ Date of Birth: ____/_____/______

Emergency Contact: ____________________ Phone: (_____) _______-_______ Relation to Patient: _______________

If the <u>patient</u> is a minor under age 18, please list the responsible party.

Last Name: ____________________ First Name: ____________________ Relation to Patient: _______________

Sex: ☐ Male ☐ Female SS#: ____________–__________–_____________ Date of Birth: _______/_______/_______

Address: ____________________ City: ____________ State: ______ Zip: ________

Home Phone: (_______)________–__________ Cell Phone: (________)________–__________ Other: (______)_______–_________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ____________________

Are you employed? ☐ Yes ☐ No ☐ Disabled ☐ Retired ☐ 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: ____________________

Please Continue on Other Side ➔

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

☐ Internet Website

☐ Physician (please complete below)

☐ Friend / Family Member / Patient

☐ Advertisement

☐ 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: ______________

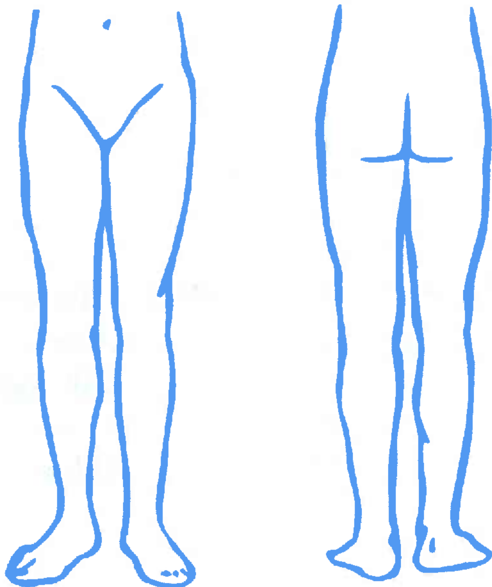
Parent / Guardian Signature: ______________________ Date: ______________

BACK FORM

Name: ______________________________ Today's Date ______________________________

Age: __________

- How long have you had your Back problem? Weeks:______ Months:______ Years:______
- Is your Back problem related to: Slip/Fall:______ Bending/Lifting:______ Injury/Auto Accident:______ None of These:______
- Have you ever had this kind of problem before? No:______ Yes (How many times):______
- Since your Back problem began, has it gotten: Better:______ Worse:______ Unchanged:______
- What position is the most comfortable to sleep in? Back:______ Stomach:______ Curled on side:______
- Do you have any problems with your buttocks or legs? Pain:______ Numbness/Tingling:______ Weakness/Loss of strength:______



On this picture, please draw where your Back, Buttocks or Legs hurt or where you have numbness/tingling.

- Which activities make pain worse? Sitting:______ Driving:______ Walking:______ Coughing/Sneezing:______ Everything:______
- Which of these treatments have you had for your Back problems?
  Physical Therapy at a clinic/hospital/other facility:______ Name of facility:____________________
  Chiropractic Treatments:______ Name of Chiropractor/Chiropractic facility:____________________
- Did any of the therapy help your Back/Leg problems? Yes:______ No:______

PLEASE COMPLETE OTHER SIDE

- Which medications have you taken for your Back problem?:

Naproxen/Aleve:______
Tylenol:______
Aspirin:______
Ibuprofen/Advil:______

Please list:
Muscle Relaxer:______
Anti-inflammatory:______
Pain Pills:______

ADDITIONAL INFORMATION

- Are you: Married:______ Single:______ Divorced:______
- What is your present job? ______________________________
- If you are not presently working, when did you last work?______________________________
- Do you smoke cigarettes/use tobacco? Yes/how much:______ No:______
- Do you drink alcohol/beer? Yes/how much:______ No:______
- Do YOU have a CURRENT or PAST medical history for the following illnesses:

Blood pressure ________
Heart Disease ________
Lung Problems ________
Kidney/Bladder ________
Thyroid ________
Stomach/colon ________
Skin Cancer/Rashes ____
Emotional/Mental ________
Eye (glaucoma/cataracts) ___
Ear/Hearing ________
Nose/Sinus ________
Arthritis ________
Diabetes ________
Cancer ________
Other ________

- List ALL medication you are taking:

____
____
____
____
____
____

Have you had any Surgery / Operations?
-Tonsils
-Appendix
-Back
-Hysterectomy
-Hernia
-Gall Bladder
-Neck
-Other

- Are you allergic to any medications? ______________________________
- Is your Mother living? Yes No

Her Medical history
-Heart Disease
-Heart Attack
-Blood Pressure
-Diabetes
-Stroke
-Lung Disease
-Cancer
______________ -Other

Is your Father living? Yes No

His Medical history
-Heart Disease
-Heart Attack
-Blood Pressure
-Diabetes
-Stroke
-Lung Disease
-Cancer
______________ -Other

Your current Weight _______ lbs. Height ______