

Patient Registration Form

Please Complete Both Sides Entirely

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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: _____

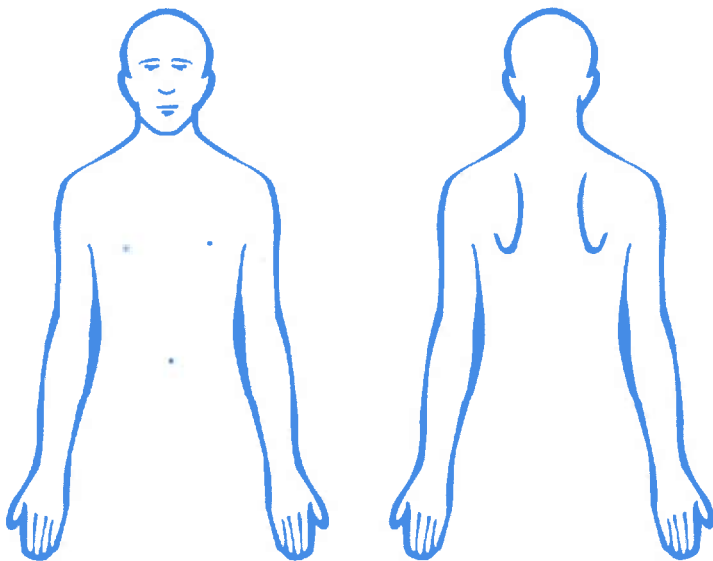
Parent / Guardian Signature: _____ Date: _____

NECK FORM

Name: _____ Today's Date _____

Age: _____

- How long have you had your **Neck** problem? Weeks: _____ Months: _____ Years: _____
- Is your **Neck** 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 **Neck** 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 shoulders or arms? Pain: _____ Numbness/Tingling: _____
Weakness/Loss of strength: _____



*On this picture, please draw where your **Neck, Shoulder or Arms** hurt or where you have numbness/tingling.*

- Which activities make pain worse? Sitting: _____ Driving: _____ Using Arms: _____
Working at a computer/or at a desk: _____ Everything: _____
- Which of these treatments have you had for your **Neck** 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 **Neck/Arm** problems? Yes: _____ No: _____

PLEASE COMPLETE OTHER SIDE

- Which medications have you taken for your **Neck** problem?:

Naproxen/Aleve: _____

Please list:

Muscle Relaxer: _____

Tylenol: _____

Anti-inflammatory: _____

Aspirin: _____

Pain Pills: _____

Ibuprofen/Advil: _____

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 _____	Emotional/Mental _____
Heart Disease _____	Eye (glaucoma/cataracts) _____
Lung Problems _____	Ear/Hearing _____
Kidney/Bladder _____	Nose/Sinus _____
Thyroid _____	Arthritis _____
Stomach/colon _____	Diabetes _____
Skin Cancer/Rashes _____	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 _____
