

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: _____

OrthoNeuro Shoulder Service
Robert J. Nowinski, DO, FAOAO
New Patient/Consultation

Name: _____ Date: _____
Age: _____ Sex: Male / Female
Referring Doctor: _____ Family Doctor: _____

Chief Complaint

1. Which shoulder are we evaluating you for today? Right / Left
2. What is the main complaint of your shoulder?
Pain / Weakness / Stiffness / Looseness / Injury

History of Shoulder Problem

1. How long have you had this problem (**duration**)?
2. How did your symptoms begin? (Circle One): Gradually over time / After an injury
If there was an injury, what was the date of injury?
Describe injury in detail:

Do you have a BWC work-related claim? Yes / No
Are you currently working? Yes / No
Who is your employer?
What is your job position?
3. What is the **location** of your shoulder pain? (Circle all that apply)
Front / Back / Side / Shoulder blade area / Arm area / Neck area
4. What is the **severity** of your pain? (Circle one) Mild / Moderate / Severe
On a scale of ten, with 0 being no pain and 10 being worst pain ever, how would
you rate your **average** daily pain? (Circle one number)
(No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst Pain Ever)
5. What is the **quality** of your shoulder pain? Sharp / Dull / Burning / Throbbing / Constant
6. What is the **context** of your symptoms?
Getting better / Getting worse / Staying same / Recurrent
7. When does the **timing** of your symptoms occur? (Circle all that apply)
During the day / At night / At rest / At work / With exercise / With overhead activity

OrthoNeuro Shoulder Service
Robert J. Nowinski, DO, FAOAO
New Patient/Consultation

Name: _____ Date _____

8. What makes your shoulder better (**modifying activities**)?
Heat / Ice / Rest / Elevation / Pain medications / Cortisone injections / Exercise

What makes your shoulder pain worse?
Overhead activity / Repetitive activity / Lifting / Carrying / Pushing / Pulling

9. What other **associated symptoms** are you having with your shoulder pain?

(circle all that apply): Numbness / Swelling / Limited movement

- Do you have neck pain? Yes / No
- Can you make your shoulder hurt by moving your neck? Yes / No
- Do you have numbness in your arm or hand? Yes / No
- Do you have upper back pain? Yes / No
- Do you have shoulder blade pain? Yes / No

10. What treatment have you had for this shoulder problem? (Check all that apply)
Anti-inflammatory medication/NSAIDs (if yes, list names):

Narcotic pain medication (If yes, list names):

Cortisone injections (If yes, list when and how many):

Physical Therapy (If yes, list when and how long):

MRI (If yes, list when and where):

EMG/Nerve Conduction Test (If yes, list when and where):

Shoulder surgery (if yes, list dates, procedure, and surgeon):

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: _____

Name: _____

Date: _____

Drug Allergies (List drug allergy and reaction)

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| | |
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Current Medications (List drug, dosage, and frequency)

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Past Medical History (List chronic medical problems)

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Surgical History (List prior surgeries and year performed)

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Family History

| Member | Living | Deceased | Age(s) | List any health problems and/or cause of death |
|----------|--------|----------|--------|------------------------------------------------|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| Sisters | | | | |
| Children | | | | |

Social History

| | |
|---------------------------------|-----------------------------------------------|
| Do you smoke? | Yes/ No |
| Do you drink alcohol? | Yes/ No |
| Marital status: | Single/ Married/ Divorced/ Separated/ Widowed |
| Occupation: | |
| Do you take recreational drugs: | Yes/ No |

Review of Systems

Please circle all symptoms you experience

| | System | Symptoms |
|----|------------------|---------------------------------------------------------------------------|
| 1 | Constitutional | unexpected weight loss, weight gain, fever, chills, fatigue |
| 2 | Eyes | corrective lenses, blurred/double vision, eye pain, redness, watering |
| 3 | ENT | headache, difficulty swallowing, nose bleeds, ringing in ears, earaches |
| 4 | Cardiovascular | chest pain, palpitations, fainting, murmurs |
| 5 | Respiratory | short of breath, wheezing, cough, tightness, inspiration pain, snoring |
| 6 | Gastrointestinal | heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stools |
| 7 | Genitourinary | frequency, urgency, difficult/painful urination, flank pain, bleeding |
| 8 | Musculoskeletal | joint pains, swelling, instability, stiffness, redness, heat, muscle pain |
| 9 | Skin | skin changes, poor healing, rash, itching, redness |
| 10 | Neurologic | numbness/tingling, unsteady gait, dizziness, tremors, seizures |
| 11 | Psychiatric | nervousness, anxiety, depression, hallucinations |
| 12 | Hematologic | easy bleeding, bruising |
| 13 | Endocrine | excessive thirst or urination, heat/ cold intolerable |
| 14 | Allergic | reaction to foods or environment |