

### 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: _____		<b>Insured DOB:</b> ____/____/____			
Insured's SS#: _____ - _____ - _____		Insured Employer: _____			

Secondary Insurance Company: _____		Phone: (____) _____ - _____			
Claims Address: _____		City: _____		State: _____ Zip: _____	
Subscriber ID / Policy Number: _____		Group Number: _____			
Name of Insured: _____		<b>Insured DOB:</b> ____/____/____			
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: \_\_\_\_\_

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## Demographics

Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Last year of school completed \_\_\_\_\_  
Occupation \_\_\_\_\_

What is the nature of today's visit: \_\_\_\_\_

Date accident or symptoms first occur \_\_\_\_\_

If an accident, where did the accident happen \_\_\_\_\_

If an accident, what time of day did the accident happen \_\_\_\_\_

Give a detailed description of accident

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did you first seek medical attention for this problem \_\_\_\_\_

Which test have you had in the past? (indicate where and when)

- \_\_\_\_\_ MRI \_\_\_\_\_
- \_\_\_\_\_ EEG \_\_\_\_\_
- \_\_\_\_\_ Disc injection \_\_\_\_\_
- \_\_\_\_\_ X-rays \_\_\_\_\_
- \_\_\_\_\_ Bone Scan \_\_\_\_\_
- \_\_\_\_\_ Cat Scan \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

What medications are you currently taking for this problem?

Medication	Started	Dose (mg)	benefits/adverse effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other medications you are currently taking

Medication	Started	Dose (mg)	benefits/adverse effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies you have to medications

\_\_\_\_\_  
\_\_\_\_\_

## Review of Systems

	Yes	No
Do you have a fever?	_____	_____
Do you have a skin rash?	_____	_____
Have you gained or lost 5 lbs. in the last six months?	_____	_____
Are you intolerant of heat or cold?	_____	_____
Do you sweat heavily at night?	_____	_____
Any skin lumps, cysts, or lesions?	_____	_____
Any changes in skin, hair, nail, or teeth?	_____	_____
Do you have eye pain, redness, or inflammation?	_____	_____
Has your vision been blurred or double?	_____	_____
Have you ever lost vision in one or both eyes?	_____	_____
Do you experience dizziness or lightheadedness?	_____	_____
Have you ever fainted, passed, or blacked out?	_____	_____
Do you have difficulties with balance or unsteadiness?	_____	_____
Do you have ear pain or fullness?	_____	_____
Do you have hearing difficulties or ringing in your ears?	_____	_____
Does your face become numb or lose sensation?	_____	_____
Is your sense of smell or taste disturbed?	_____	_____
Are your teeth sensitive to cold, hot or other?	_____	_____
Do your sinuses discharge blood or mucus?	_____	_____
Do you have chest pain?	_____	_____
Does your heart race or skip beats?	_____	_____
Do you become short of breath?	_____	_____
Do your feet or ankles swell?	_____	_____
Do you cough up phlegm or blood?	_____	_____
Do you have a persistent cough or wheeze?	_____	_____
Any pain or discomfort in your abdomen?	_____	_____
Has your appetite changed?	_____	_____
Have you had nausea or vomiting?	_____	_____
Do you suffer from constipation, diarrhea or excess gas?	_____	_____
Has there been any change in you bowel movements?	_____	_____
Have you been jaundiced?	_____	_____
Do you have burning or pain with urination?	_____	_____
Do you have to urinate frequently?	_____	_____
Do you have to get up often at night to urinate?	_____	_____
Do you experience weakness of the arms or legs?	_____	_____
Any numbness or tingling of the arms or legs?	_____	_____
Do you have headaches or facial pain?	_____	_____
Do you have neck or back pain?	_____	_____
Do you have muscle pain or swelling?	_____	_____
Do you joint pain or swelling?	_____	_____
Do you have difficulty with concentration or memory?	_____	_____
Do you often feel depressed?	_____	_____
Do you often feel anxious or nervous?	_____	_____
Do you often feel tired or sleepy?	_____	_____
Do you have any difficulty falling asleep or staying asleep?	_____	_____

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## Past Medical History

Have you ever had any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> heart disease     | <input type="checkbox"/> sinusitis               |
| <input type="checkbox"/> cancer            | <input type="checkbox"/> ear infection           |
| <input type="checkbox"/> lung disease      | <input type="checkbox"/> bronchitis/asthma       |
| <input type="checkbox"/> hypertension      | <input type="checkbox"/> sore throat/tonsillitis |
| <input type="checkbox"/> cholesterol       | <input type="checkbox"/> arthritis               |
| <input type="checkbox"/> stroke            | <input type="checkbox"/> anemia                  |
| <input type="checkbox"/> ulcer             | <input type="checkbox"/> dental disease          |
| <input type="checkbox"/> diabetes          | <input type="checkbox"/> skin disorder           |
| <input type="checkbox"/> hypoglycemia      | <input type="checkbox"/> sleep disorder          |
| <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> mononucleosis           |
| <input type="checkbox"/> brain tumor       | <input type="checkbox"/> glaucoma                |
| <input type="checkbox"/> encephalitis      | <input type="checkbox"/> lumps/cysts             |
| <input type="checkbox"/> meningitis        | <input type="checkbox"/> deep venous thrombosis  |
| <input type="checkbox"/> headaches         | <input type="checkbox"/> bleeding disorder       |
| <input type="checkbox"/> thyroid           | <input type="checkbox"/> tuberculosis            |
| <input type="checkbox"/> snoring           | <input type="checkbox"/> hepatitis A or B        |
| <input type="checkbox"/> panic attacks     | <input type="checkbox"/> aneurysm                |
| <input type="checkbox"/> mental illness    | <input type="checkbox"/> other (explain)         |

Please list all prescription and non-prescription medications you have taken in the past (please indicate if the medication was for your current problem):

Medication	Dose (mg)	How many pills per day	Current problem (yes)

Please list surgeries and hospitalization

year	hospital/City	Type of surgery/treatment

### OB/GYN

At what age did your menstrual cycle begin? \_\_\_\_\_ stop? \_\_\_\_\_

Are your cycles regular? \_\_\_\_\_ yes \_\_\_\_\_ no

Do you experience any menstrual related problems? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, explain \_\_\_\_\_

Method of birth control? \_\_\_\_\_

How many pregnancies? \_\_\_\_\_ How many births? \_\_\_\_\_

Where they any complications related to pregnancy, labor or delivery? \_\_\_\_\_

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## Social History

Check any that apply:

\_\_\_\_\_ single      \_\_\_\_\_ married      \_\_\_\_\_ divorced      \_\_\_\_\_ widowed

Children's names and ages

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Have you ever smoked tobacco? \_\_\_\_\_ yes      \_\_\_\_\_ no

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 now use illicit drugs? \_\_\_\_\_ yes      \_\_\_\_\_ no

## Family History

Indicate who among your close relatives may have had any of the following ailments.

heart disease	_____	seizures/epilepsy	_____
cancer	_____	brain tumor	_____
lung disease	_____	headaches	_____
hypertension	_____	thyroid	_____
cholesterol	_____	arthritis	_____
stroke	_____	muscular disease	_____
ulcer	_____	snoring	_____
diabetes	_____	panic attacks	_____
hypoglycemia	_____	mental illness	_____

Physician comments:

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