

### 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: \_\_\_\_\_

---

**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 \_\_\_\_\_