OrthoNeuro

A Multi-Specialty Center of Excellence

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

Patient Registration Form

Today's Date: ___________________ **Please Complete Both Sides Entirely** 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: ____________________

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NEW PATIENT INFORMATION

NAME: ______________________________ AGE: _______ DATE: ____________

REFERRING DOCTOR/THERAPIST: __________________

SELF REFERRAL (if so, circle)

Are you: ☐Male ☐Female

☐Right handed ☐Left handed ☐Ambidextrous

CHIEF COMPLAINT

Reason for visit: ____

Location of your pain:

☐Head	☐Shoulder	☐Mid Back	☐Leg	☐ Ankle/Foot	☐Wrist/Hand
☐Neck	☐Headaches	☐Low Back	☐Knee	☐Hips/Buttocks	☐Arm

HISTORY OF PRESENT ILLNESS

Date of injury or symptom onset: __________________

Type of injury: ☐Sports Injury ☐Job Accident

☐Car Accident (Were you the ☐Driver or ☐Passenger? Seatbelted? ☐No ☐Yes)

☐Other (explain): ____

Please describe how you injured yourself: ______________________________

____

____

____

____

Please describe your current symptoms: ________________________________

____

____

____

Circle the number that corresponds to the **severity** of your pain on a scale of 0-10.
"0" means no pain and "10" is the worst pain you can imagine.

At it's worst:	0	1	2	3	4	5	6	7	8	9	10
At it's best:	0	1	2	3	4	5	6	7	8	9	10

Which of the following best describes the **character** of your pain:

Timing:

☐Continuous, steady, constant

☐Rhythmic, periodic, intermittent

☐Brief, momentary, transient
(Frequency: ____ Duration: __________)

Quality:

☐Throbbing ☐Burning ☐Superficial

☐Aching ☐Tingling/numbness ☐Deep

☐Sharp ☐Dull ☐___________________

What makes your pain **worse**? ____

What makes your pain **better**? ____

How long/far can you: Sit ____________ Stand ____________ Walk ____________

Since your injury is your pain: ☐Better ☐Same ☐Worse

If your pain is changed, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ☐No ☐Yes

PREVIOUS TREATMENT

Have you had treatment since your injury? ☐No ☐Yes Have you been to the ER for this? ☐No ☐Yes
Have you had any of the following tests or procedures performed:

X-Rays? ☐No ☐Yes MRI? ☐No ☐Yes Epidurals? ☐No ☐Yes

CT Scan? ☐No ☐Yes EMG? ☐No ☐Yes

Other (please explain) ____

Medical:

Dr. ___________ Date of 1st visit ____________________ Last visit ____________________
Diagnosis given ____
Medications given ____
Treatment provided ____

Chiropractic: ☐No ☐Yes

Dr. ___________ Date of 1st visit ____________________ Last visit ____________________
Diagnosis given ____
Frequency: ☐Every Day ☐Three times/week ☐Two times/week ☐Weekly

Has it helped? ☐No ☐Yes

Physical Therapy: ☐No ☐Yes

Therapist _____________ Date of 1st visit _____________ Last visit ____________________

Has it helped? ☐No ☐Yes Home exercise program given? ☐No ☐Yes

CURRENT MEDICATIONS:

NAME	DOSAGE	HOW OFTEN DO YOU TAKE THIS PER DAY
____________________	_____________	___________________________
____________________	_____________	___________________________
____________________	_____________	___________________________
____________________	_____________	___________________________
____________________	_____________	___________________________
____________________	_____________	___________________________
____________________	_____________	___________________________
____________________	_____________	___________________________

MEDICATION ALLERGIES ☐No ☐Yes

If yes, please list:

Name	Reaction
____________________	___________________________
____________________	___________________________
____________________	___________________________

Are you allergic or had any reaction to iodine, shellfish, IVP dye, or contrast media? ☐No ☐Yes

PAST MEDICAL HISTORY

☐Anxiety	☐Heart Attack	☐Polio	☐Thyroid trouble	☐Depression	☐Hypertension
☐Asthma	☐Heart Murmur	☐Stroke	☐High Cholesterol	☐Alcoholism	☐Liver disease
☐Cancer	☐Lung Disease	☐Parkinson’s	☐Rheumatic Fever	☐Hepatitis	☐Chronic pain
☐Diabetes	☐Ulcers/PUD	☐Arthritis	☐Claustrophobia	☐Other ____________________	

Have you ever had similar symptoms/injury before? ☐No ☐Yes

If yes, when: _______________ Please describe briefly: ____

____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐No ☐Yes

If yes, please list type of surgery and approximate date:

1. ________________________ 2. ________________________ 3. ________________________

4. ________________________ 5. ________________________ 6. ________________________

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐Anxiety	☐Heart Attack	☐Polio	☐Thyroid trouble	☐Depression	☐Hypertension
☐Asthma	☐Heart Murmur	☐Stroke	☐High Cholesterol	☐Alcoholism	☐Liver disease
☐Cancer	☐Lung Disease	☐Parkinson’s	☐Rheumatic Fever	☐Hepatitis	☐Chronic pain
☐Diabetes	☐Ulcers/PUD	☐Arthritis	☐Claustrophobia	☐Psychiatric illness	

☐Other ____________________

SOCIAL HISTORY
Marital Status: (Check one or more)

☐Single ☐Married ☐Divorced ☐Widowed ☐"Living together" ☐Separated
Number of children: ___________ Ages: ______ ______ ______ ______ ______ ______

Do you smoke? ☐No ☐Yes How much? ________________________________

Previous Smoker? ☐No ☐Yes When stopped? _____________________________

Do you drink alcohol? ☐No ☐Yes How much? ________________________________
Coffee, tea, cola beverages (cups/glasses/cans per day) ____

Do you use recreational drugs? ☐No ☐Yes What type/how often? ______________________________

Are you currently employed? ☐No ☐Yes If yes, type of job ___________________________________

REVIEW OF SYSTEMS: Please mark those items which you currently experience:

GENERAL
□Fever □Weight gain □Weight loss □Fatigue □Chills
□Weakness □Night sweats

DERMATOLOGIC
□Jaundice □Itching/rash □Lesions □Easy bruising

HEAD/HEARING& VISION
□Trauma □Headaches □Tenderness □Dizziness
□Blindness □Blurred vision □Ringing in ears
□Changes/loss □Discharge □Rings around lights
□Double vision □Light sensitivity □Glasses

PULMONARY
□Wheezing □Shortness of breath □Chronic cough □Coughing up blood

CARDIOVASCULAR
□Chest pain □Leg swelling □Racing heart □Shortness of breath with exertion

GASTROINTESTINAL
□Nausea □Abdominal pain □Bloody stool □Constipation □Diarrhea
□Vomiting □Stool color changes □Heartburn □Incontinence of bowels

GENITOURINARY
□Blood in urine □Vaginal discharge □Pregnancy □Pain/burning on urination
□Incontinence □Venereal disease □Sexual problems □Urgency/frequency with urination
□Painful menstruation □Menopause □Irregular menstruation

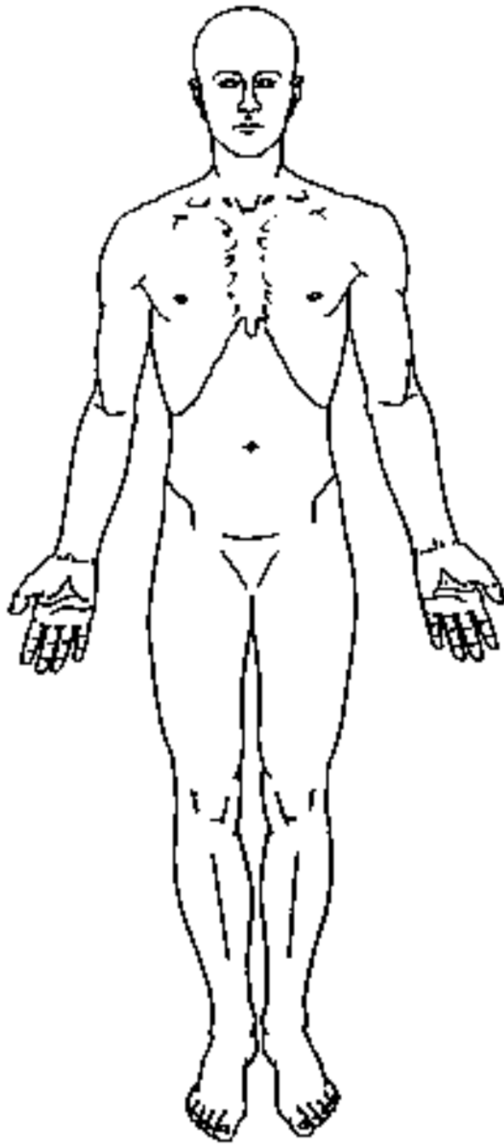
MUSCULOSKELETAL
□Arthritis □Joint swelling □Trauma

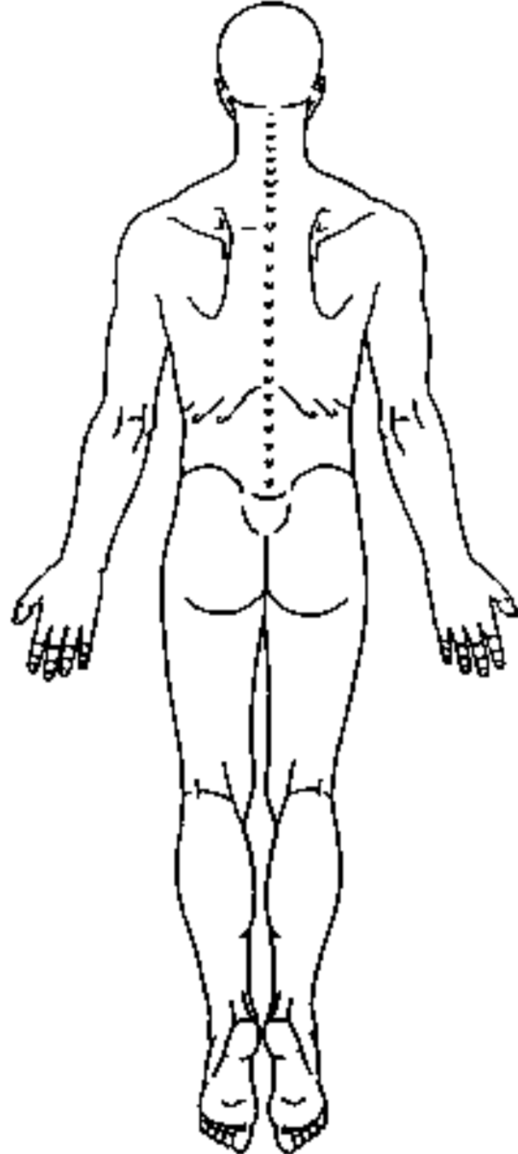
NEUROLOGICAL
□Loss of Sensation □Seizures □Numbness and Tingling

PSYCHOLOGICAL
□Sadness □Anxiety □Depression

Mark on the areas on your body where you feel the described sensations. Use the symbols listed.
Mark areas of radiating pain or numbness as well. Include all affected areas.

Numbness	**Tingling**	**Burning**	**Stabbing/Sharp**	**Aching**	**Cramping**
o o o	**: : : :**	**X X X**	////	^^^	□□□





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