

PATIENT REGISTRATION FORM (WEBSITE**)**

(PLEASE PRINT LEGIBLY)

Female Male Social Security #: _____ D.O.B: ____ / ____ / ____

Patient Name: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Check appropriate box: Minor Single Married Divorced Separated Widowed

If a minor, Guardian or Responsible Party Name: _____ Relation: _____
 Address: _____ Phone: _____

Patient's Employer: _____

Address: _____

Work Phone: _____ X _____ FT PT Ret WC Other: _____

Primary Care Physician Name: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Pharmacy Name: _____ **Phone:** _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company: _____

Are you the subscriber? Yes No If no, please complete the next section.

FULL Name of Subscriber: _____ Relation: _____

D.O.B: ____ / ____ / ____ Employer: _____ Work Phone: _____ X

Do you have a secondary Insurance? Yes No If yes, please complete below.

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: _____

Are you the subscriber? Yes No If no, please complete the next section.

FULL Name of Subscriber: _____ Relation: _____

D.O.B: ____ / ____ / ____ Employer: _____ Work Phone: _____ X

*******EMERGENCY CONTACT INFORMATION*******

Name: _____ Phone: _____ Relation: _____

Please complete both sides of this form ----->

PATIENT NAME: _____

Medical History Form

Please briefly describe your orthopedic condition and affected side (right, left or both).

Approximate date the problem began: _____

How did this problem begin? _____

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Have you tried physical therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you tried medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is this a work related injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is this an auto related accident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please tell us about any past surgical procedures you may have had performed:

ALLERGIES:

Environmental & Drug

Reaction

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Have you ever experienced the following?

- | | |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nerve disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No | Circulation Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/intestinal Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No | Breathing/Lung disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/Bladder Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis or blood clots? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ease of Bruising? <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged bleeding from cuts? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other? <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional/Psychological problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered yes to any of the above, please specify: _____

Please list the medications you are currently taking:

| <u>Medication Name</u> | <u>Dose</u> | <u>X's a day</u> |
|------------------------|-------------|------------------|
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|-------------------------------|----------------------------------------------------------|-------------------------------------------|
| Do you use tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES, What kind? _____ How often? _____ |
| Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Nursing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Using the birth control pill? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Additional information you believe will assist in your treatment: _____

use this form only if this injury is the result of an accident

THIRD PARTY LIABILITY INFORMATION

Date of accident: _____ Type: _____

Location of Accident: _____

How did the accident occur? _____

Are you back to work? Yes No

Are you Full Time or Part Time? FULL PART TIME

What is your current disability status? _____

Name of Insurance Company Handling the Claim: _____

Billing Address: _____

Contact Name: _____ Title: _____

Phone: _____ X _____ Fax: _____

Claim Number: _____

Do you have legal representation? Yes No

If yes:

Name of Attorney: _____

Address: _____

Phone: _____ Fax: _____

Contact Name: _____

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