

# PATIENT REGISTRATION

Patient's Name \_\_\_\_\_ SS# \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone # \_\_\_\_\_

E-Mail Address (Please Print Clearly): \_\_\_\_\_

Marital Status \_\_\_\_\_ Male / Female Parent's Name if Minor \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_

Employment Address \_\_\_\_\_ Phone \_\_\_\_\_

**\*Emergency Contact** \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to You \_\_\_\_\_ Alternative PH# \_\_\_\_\_

**\*Date of Injury or Onset of Problem** \_\_\_\_\_

Date of Surgery OR Emergency Room Visit \_\_\_\_\_

**\*Referred By:** Who referred you to see us for treatment? \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Chiropractor \_\_\_\_\_ Family \_\_\_\_\_ Friend \_\_\_\_\_ Emergency Room \_\_\_\_\_

Other(specify) \_\_\_\_\_

**\*Orthopedic problem(s) you would like evaluated today?** Right / Left \_\_\_\_\_

Injury \_\_\_\_\_ Accident \_\_\_\_\_ Woke up with pain \_\_\_\_\_ Don't know \_\_\_\_\_ Other \_\_\_\_\_

**Explain** how injury/accident/problem occurred \_\_\_\_\_

On a scale from 0 to 10 with 0 being no pain and 10 being the worst pain possible, how is your pain today? \_\_\_\_\_

Prior Doctor Seen \_\_\_\_\_ Phone# \_\_\_\_\_ Date \_\_\_\_\_

**\*X-Ray taken - Where & When** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_

City/Zip \_\_\_\_\_ Phone# \_\_\_\_\_

**Specialty** (circle one): Internal Medicine Family Practice Pediatrics OB-GYN Other

**\*\*IF YOU ARE IN AN HMO YOU MUST HAVE A REFERRAL TO RECEIVE SERVICE\*\***

**Self-Pay Patients:** Payment is due time of service unless arrangements have been made.

## Method of Payment:

\_\_\_\_\_ PPO \_\_\_\_\_ HMO \_\_\_\_\_ POS \_\_\_\_\_ IME

\_\_\_\_\_ Worker's Comp. \_\_\_\_\_ Medicare \_\_\_\_\_ Attorney \_\_\_\_\_ Personal Injury

\_\_\_\_\_ Medicaid \_\_\_\_\_ Self-Pay \_\_\_\_\_ Auto \_\_\_\_\_ Other \_\_\_\_\_

Workmans Comp Claim # \_\_\_\_\_ Attorney Phone Number \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Medical Group if in HMO:** \_\_\_\_\_ **IPA** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**I agree to pay all costs and expenses, including reasonable attorney's fees, incurred to collect any unpaid balances**

**ASSIGNMENT:** I authorize and request payment of medical benefits to ILLINOIS ORTHOPEDIC AND SPORTSMEDICINE CENTERS for services.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_