



REGISTRATION

DATE _____

PATIENT _____

LAST NAME

FIRST NAME

MIDDLE INITIAL

HOME PHONE _____ EMAIL _____

CELL PHONE _____ PERMISSION TO: TEXT | YES NO EMAIL | YES NO

STREET ADDRESS _____ SOCIAL SECURITY NO. _____

CITY _____ STATE _____ ZIP _____ BIRTHDAY _____ AGE _____

RACE _____ ETHNICITY _____ MALE FEMALE

ATTORNEY _____ ATTORNEY PHONE _____

HOW WOULD YOU LIKE TO RECEIVE YOUR BILLING STATEMENTS? PAPER EMAIL TEXT

EMPLOYER

EMPLOYER NAME _____ JOB TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ PHONE _____

PATIENT INSURANCE INFORMATION

INSURED'S NAME _____

LAST NAME

FIRST NAME

MIDDLE INITIAL

PHONE NUMBER _____

RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

CONDITION RELATED TO ILLNESS EMPLOYMENT AUTO OTHER

INSURED/SUBSCRIBER NAME _____ SOCIAL SECURITY NO. _____

INSURANCE ID NO. _____ INSURED'S DATE OF BIRTH _____

INSURANCE COMPANY NAME _____

ADDRESS/PHONE _____ CLAIM NO. _____

POLICY NO. _____ EFFECTIVE DATE _____

REFERRAL

HOW WERE YOU REFERRED TO THE OFFICE?

BY A PATIENT-NAME _____ BY A PHYSICIAN-NAME _____

INSURANCE PLAN EMPLOYER INTERNET RADIO OTHER _____

PATIENT AGREEMENT

I, the undersigned, have insurance coverage with _____ (INSURANCE COMPANY) and assign directly to the **Ohio Sports & Spine Institute LTD.**, providers all my medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

SIGNATURE OF INSURED/GUARDIAN

DATE





REVIEW OF SYSTEMS

PATIENT _____

DATE _____

Check all that apply to indicate if you currently have any of the symptoms below.

GENERAL

- Chills/Fever
- Loss of Appetite
- Weight Loss
- Excessive Fatigue

ALLERGY

- Seasonal Allergies

NEUROLOGIC

- Headache
- Numb/Tingling
- Incoordination
- Dizziness
- Seizures
- Drop Attacks

EYES

- Eye Pain
- Blurred/Double Vision
- Vision Changes

ENT

- Hearing Loss
- Difficulty Swallowing
- Ringing Ears

RESPIRATORY

- Productive Cough
- Coughing Blood
- Asthma
- Wheezing
- Trouble Breathing
- COPD

CARDIAC

- Chest Pain
- Ankle Swelling
- High Cholesterol
- Palpitation
- Shortness of Breath
- High Blood Pressure

GI

- Abdominal Pain
- Nausea/Vomiting
- Blood in Stool
- Persistent Diarrhea
- Difficulty Swallowing
- Heartburn/Indigestion
- Bowel Habit Changes
- Dark Black Stools

GU

- Painful Urination
- Frequent Urination
- Urinary Incontinence
- Loss of Bladder Control
- Blood in Urine

HEME

- Night Sweats
- Easy Bruising
- Bleeding Problems

DERMATOLOGIC

- Rash
- Itching
- Hives

PSYCH

- Depression
- Unusual Stress
- Anxiety
- Claustrophobia
- Difficulty Sleeping

ENDOCRINE

- Diabetes
- Thyroid Disease

CANCER

- Yes
- No

PACEMAKER

- Yes
- No