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 fianancially 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

HISTORY

PATIENT ______________________

DATE ______________________

Please indicate "none" in all areas where you have no information to enter.

MARITAL STATUS SINGLE MARRIED SEPARATED DIVORCED WIDOWED

EDUCATION HIGH SCHOOL COLLEGE POST GRADUATE DID NOT FINISH HIGH SCHOOL

PRIOR SURGERIES Please list all previous surgeries.

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

CURRENT MEDICAL CONDITIONS Please list all current health problems

NAME OF YOUR PRIMARY CARE PHYSICIAN ______________________

MEDICATIONS List all medications (prescription and non-prescription) you are currently taking.

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

PHARMACY ______________ LOCATION ______________ PHONE ______________

ALLERGIES List all alergies to medication or environment.

MEDICATION	REACTION	ENVIROMENTAL	REACTION

FAMILY HISTORY

RELATION	CURRENT AGE	HEALTH CONDITIONS	DECEASED AGE	CAUSE OF DEATH
FATHER				
MOTHER				
SIBLING				
SIBLING				

SOCIAL HISTORY

ALCOHOL USE | YES NO Frequency ______________________

TOBACCO USE | YES NO Packs/Day __________ Duration __________ Quit Date __________

CAFFEINE USE | YES NO Frequency ______________________

DRUG USE | YES NO Frequency ______________________

EMPLOYER NAME ______________________ **JOB TITLE** ______________

CURRENT WORK STATUS RETIRED REGULAR FULL-TIME REGULAR PART-TIME LIGHT DUTY DISABILITY UNEMPLOYED STUDENT