REGISTRATION

Date: ______________ Home Phone: ______________ Cell Phone: __________________

Patient: ____
Last Name First Name Initial

Street Address: ____

City: ____ State: _____________ Zip: ________________

Sex: ❑ M ❑ F Age: ____ Birthdate: __________ Social Security No.: _________________

E-mail Address: __________________________________ Race: _______________ Ethnicity: ______________

I give OSSI permission to e-mail me: ❒ Yes ❒ No

EMPLOYER

Employer Name ____

Job Title ____

Address ____

City ______________________ State ______________ Zip ___________ Phone ____________________________

EMERGENCY CONTACT

Name: ______________________________________ Phone No.: ____________ Relationship: ____________

PATIENT INSURANCE INFORMATION

Insured's Name: _____________________________________ Nearest Relative: _______________________
Last Name First Name Initial

Phone No.: _________________________

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 this office?

☐ By a Patient-Name: _____________________________ ☐ By a Physician-Name: __________________________

☐ Phone Book ☐ Insurance Plan ☐ Employer ☐ Internet ☐ Radio ☐ Other__________________________

PATIENT AGREEMENT

ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage with ________________________________
Name of 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

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

Marital Status:
□ Single □ Married □ Separated □ Divorced □ Widowed

EDUCATION: (Circle highest level attained) 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 Name: ____________ Location: ____________ Phone: ____________

ALLERGIES: List all allergies to medication or environment.

Medications	Reaction	Environmental	Reaction

FAMILY HISTORY:

	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

Name: ____________ Date: ____________

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REVIEW OF SYSTEMS: Please check past or present to indicate whether you have any of the symptoms.

		Past	Present		Past	Present
General:	Chills/Fever	□	□	Weight Loss	□	□
	Loss of Appetite	□	□	Excessive Fatigue	□	□
Allergy:	Seasonal Allergies	□	□			
Neurologic:	Headache	□	□	Dizziness	□	□
	Numb/Tingling	□	□	Seizures	□	□
	Incoordination	□	□	Drop Attacks	□	□
Eyes:	Eye Pain	□	□	Vision Changes	□	□
	Blurred/Double Vision	□	□			
ENT:	Hearing Loss	□	□	Ringing Ears	□	□
	Difficulty Swallowing	□	□			
Respiratory:	Productive Cough	□	□	Wheezing	□	□
	Coughing Blood	□	□	Trouble Breathing	□	□
	Asthma	□	□	COPD	□	□
Cardiac:	Chest Pain	□	□	Palpitation	□	□
	Ankle Swelling	□	□	Shortness of Breath	□	□
	High Cholesterol	□	□	High Blood Pressure	□	□
GI:	Abdominal Pain	□	□	Difficulty Swallowing	□	□
	Nausea/Vomiting	□	□	Heartburn/Indigestion	□	□
	Blood in Stool	□	□	Bowel Habit Changes	□	□
	Persistent Diarrhea	□	□	Dark Black Stools	□	□
GU:	Painful Urination	□	□	Loss of Bladder Control	□	□
	Frequent Urination	□	□	Blood in Urine	□	□
	Urinary Incontinence	□	□			
Heme:	Night Sweats	□	□	Bleeding Problems	□	□
	Easy Bruising	□	□			
Muscular:	Joint Pain	□	□	Muscle Pain/Weakness	□	□
Dermatologic:	Rash	□	□	Hives	□	□
	Itching	□	□			
Psych:	Depression	□	□	Claustrophobia	□	□
	Unusual Stress	□	□	Difficulty Sleeping	□	□
	Anxiety	□	□			
Endocrine:	Diabetes	□	□	Thyroid Disease	□	□

Cancer: Yes □ No □

Pace Maker: Yes □ No □

Name: ___________________________________ Date: ______________________________

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