REGISTRATION

Date:	Home Phone:	Cell	Phone:		-	
Patient: Last Nam		First N			7.22.1	
Street Address:					Initial	
City:						
Sex: □ M □ F	Age:	Birthdate:		Social Security N	No.:	
E-mail Address:	1 : 0001	Race	e:		Ethnicity:	
EMPLOYER	1 give OSSI perm	nission to e-mail me:	☐ Yes	□ No		
Employer Name						
Job Title						
Address						
City	State	Zip	Ph	one		
EMERGENCY CONTA	<u>·CT</u>					
Name:		Phon	ne No.:		Relationship:	
PATIENT INSURANCE	E INFORMATION					
Insured's Name: Last Nam	ne First Name	 Initial	Nearest 1	Relative:		
Phone No.:		initial				
Relationship To Insured:	\square Self \square S _I	oouse	\Box Child	□ Othe	r	
Condition Related To:	□ Illness □ Eı	mployment	□ Auto	□ Othe	r	
Insured/Subscriber Name	:	Soc	ial Security 1	No.:		
Insurance ID No.:		Insured's Da	ite of Birth: _			
Insurance Company Nam	e:					
Address/Phone:			Claim N	lo.:		
Policy No.:	Policy No.: Effective Date:					
REFERRAL						
How were you referred to	this office?					
☐ By a Patient-Name:	a Patient-Name: By a Physician-Name:					
☐ Phone Book ☐ Insu	rance Plan Employ	yer Internet	□ Radio □	Other		
PATIENT AGREEMEN						
ASSIGNMENT AND I	RELEASE: I, the und	dersigned, have i	nsurance co	verage with	Nama of Incurance Co	mpany
and assign directly to the to me for services rendere authorize the doctor to rel my insurance submissions	OHIO SPORTS & SPIN ed. I understand that I ar lease all information nec	NE INSTITUTE L m financially respo	TD., provide onsible for all	rs all my medical charges whether	l benefits, if any, other or not paid by insuran	wise payabl nce. I hereb

Date

Signature of Insured/Guardian

Note: Plea	ase indicate "none" i	n all areas where	e you have no	information	to enter.			
Marital Sta	itus:							
\square Single	□ Married	\square Separated	$ \Box \ Divorced$	□ Widov	wed			
EDUCATION	ON: (Circle highest lev	vel attained) High	School Col	lege Post C	Graduate Did not fin	ish high school		
PRIOR SU	RGERIES: Please	list all previous	s surgeries.					
	Type of Surgery		Date		Type of Surgery		Date	
			I.				L	
CUDDENI	MEDICAL COM		1. 4 11	4.1 141				
CURRENT	MEDICAL CONI	DITTONS: Plea	se list all cui	rent health	problems.			
Name of W	D C C	Namai ai a						
Name of Yo	our Primary Care i	<u>nysician</u> :						
MEDICAT	IONS: List all med	dications (presc	ription and 1	non-prescri _l	otion) you are curre	ntly taking.		
	Medication Name		Dosage		Medication Name		Dosage	
		l .						
Pharmacy N	Pharmacy Name:		Location:		Phon	ie:		
ALI ERCII	ES: List all allergie	es to medication	or environr	mont				
	edications	Reacti			ironmental I		Reaction	
FAMILY H	HISTORY:							
	Current Age	Heal	th Condition	ıs	Deceased Age	Death		
Father								
Mother								
Sibling Sibling								
Sibiling								
SOCIAL HI								
Alcohol Use: Tobacco Use		Frequen	cy:	Duration	Quit	Dota:		
Caffeine Use		· ·						
Drug Use:	□ Yes □ No	Frequen	cy:					
Employer No	ime			Joh Titlo	:			
Current Wo					·			
Retired		gular: Full-Time	Regular	: Part-Time	Light Duty			
Disabil	ity Un	employed	Student	•				
Name:			Det	a·				
c:\forms\Marital	Status		Date	··				

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

Past Present Past Pas								
Allergy: Seasonal Allergies			Past	Present	t		Past	Present
Allergy: Seasonal Allergies	General:	Chills/Fever				Weight Loss		
Neurologic: Headache Numb/Tingling Incoordination		Loss of Appetite				Excessive Fatigue		
Neurologic: Headache Numb/Tingling Incoordination								
Numb/Tingling Incoordination	Allergy:	Seasonal Allergies						
Numb/Tingling Incoordination								
Eyes: Eye Pain Blurred/Double Vision	Neurologic:					Dizziness		
Eyes: Bured/Double Vision Blurred/Double Vision Blood Brain Blood Breathing Coughing Blood Asthma COPD Breathing COPD Breathing COPD Breathing COPD Breathing COPD Breathing COPD Breathing Blood Breathing COPD Breathing Breathing COPD Breathing Breathing COPD Breathing Breathing COPD Breathing Breathin		Numb/Tingling				Seizures		
Eyes: Bye Pain Blurred/Double Vision		Incoordination				Drop Attacks		
Blurred/Double Vision						•		
ENT: Hearing Loss Difficulty Swallowing Difficulty Swallowing Difficulty Swallowing Difficulty Swallowing Difficulty Swallowing Diod Asthma Difficulty Swallowing Diod Asthma Difficulty Swallowing Diod Asthma Difficulty Swallowing Diod Diod Diod Diod Diod Diod Diod Diod	Eyes:	Eye Pain				Vision Changes		
Respiratory: Productive Cough		Blurred/Double Vision						
Respiratory: Productive Cough								
Respiratory: Productive Cough Coughing Blood Asthma COPD Cordiac: Chest Pain Ankle Swelling High Cholesterol Blood in Stool Persistent Diarrhea Dark Black Stools Persistent Urination Urinary Incontinence Blood in Urine Heme: Night Sweats Easy Bruising Muscular: Dermatologic: Rash Itching Psych: Depression Unusual Stress Anxiety Pace Maker: Yes No Wheezing Wheezing Wheezing Wheezing Dall Wheezing Wheezing Dall Wheezing COPD Dall Wheezing Trouble Breathing COPD Dall Wheezing Trouble Breathing Dall Wheezing Trouble Breathing Dall Breathing Dall Breathing Dall Breathing Dall Breathing Dall Breathing Dall Heartburn/Indigestion Bowel Habit Changes Dark Black Stools Dark Black Tohning Dark Black Stools Dark Black Stools Dark Black Tohning Dark Black Tohning Dark Black Stools Dark Black Tohning Dark B	ENT:	Hearing Loss				Ringing Ears		
Respiratory: Productive Cough		Difficulty Swallowing						
Coughing Blood Asthma		ý e						
Coughing Blood Asthma	Respiratory:	Productive Cough				Wheezing		
Asthma	1 ,							
Cardiac: Chest Pain Ankle Swelling High Cholesterol GI: Abdominal Pain Nausea/Vomiting Blood in Stool Persistent Diarrhea GU: Painful Urination Urinary Incontinence Beasy Bruising Muscular: Dermatologic: Rash Itching Palpitation Shortness of Breath High Blood Pressure Difficulty Swallowing Heartburn/Indigestion Bowel Habit Changes Dark Black Stools Bowel Habit Changes Dark Black Stools Blood in Urine Claustrophobia Unusual Stress Anxiety Difficulty Sleeping Thyroid Disease Thyroid Disease								
Ankle Swelling High Cholesterol GI: Abdominal Pain Nausea/Vomiting Blood in Stool Persistent Diarrhea GU: Painful Urination Urinary Incontinence Heme: Night Sweats Easy Bruising Muscular: Dermatologic: Rash Itching Psych: Depression Unusual Stress Anxiety Endocrine: Diabetes Difficulty Swallowing Heartburn/Indigestion Bowel Habit Changes Dark Black Stools Loss of Bladder Control Blood in Urine Loss of Bladder Control Blood in Urine Bleeding Problems Hives Claustrophobia Difficulty Sleeping Thyroid Disease Thyroid Disease		7 ISTITUTE	ш			COLD	ы	ш
Ankle Swelling High Cholesterol GI: Abdominal Pain Nausea/Vomiting Blood in Stool Persistent Diarrhea GU: Painful Urination Urinary Incontinence Heme: Night Sweats Easy Bruising Muscular: Dermatologic: Rash Itching Psych: Depression Unusual Stress Anxiety Endocrine: Diabetes Difficulty Swallowing Heartburn/Indigestion Bowel Habit Changes Dark Black Stools Loss of Bladder Control Blood in Urine Loss of Bladder Control Blood in Urine Bleeding Problems Hives Claustrophobia Difficulty Sleeping Thyroid Disease Thyroid Disease	Cardiac:	Chest Pain	П	П		Palnitation	П	П
High Cholesterol	Curaiuc.							
GI: Abdominal Pain Nausea/Vomiting Blood in Stool Persistent Diarrhea GU: Painful Urination Frequent Urination Urinary Incontinence Basy Bruising Muscular: Dermatologic: Rash Itching Psych: Depression Unusual Stress Anxiety Difficulty Swallowing Heartburn/Indigestion Bowel Habit Changes Dark Black Stools Blood in Urine Blood in Urine Blood in Urine Muscle Pain/Weakness Claustrophobia Difficulty Sleeping Claustrophobia Difficulty Sleeping Thyroid Disease Pace Maker: Yes No								
Nausea/Vomiting Blood in Stool Persistent Diarrhea GU: Painful Urination Frequent Urination Urinary Incontinence Blood in Urine Claustrophobia Claustrophobia Unusual Stress Anxiety Bendocrine: Diabetes Cancer: Yes No Pace Maker: Yes No Blood in Urine Claustrophobia Difficulty Sleeping Thyroid Disease		rigii Cholesteroi	Ш	Ш		High Blood Flessure	Ш	Ц
Nausea/Vomiting Blood in Stool Persistent Diarrhea GU: Painful Urination Frequent Urination Urinary Incontinence Blood in Urine Claustrophobia Claustrophobia Unusual Stress Anxiety Bendocrine: Diabetes Cancer: Yes No Pace Maker: Yes No Blood in Urine Claustrophobia Difficulty Sleeping Thyroid Disease	GI:	Abdominal Pain				Difficulty Swallowing		
Blood in Stool Persistent Diarrhea	GI.							
Persistent Diarrhea								
GU: Painful Urination								
Frequent Urination Urinary Incontinence		Persistent Diarrhea				Dark Black Stools		
Frequent Urination Urinary Incontinence	CIL	D-: C-1 II-:4:				Lara CDI-11- Cartai		
Heme: Night Sweats Easy Bruising Muscular: Joint Pain Muscle Pain/Weakness Hives Dermatologic: Rash Itching Psych: Depression Unusual Stress Anxiety Diabetes Thyroid Disease Cancer: Yes No	GU:							
Heme: Night Sweats Easy Bruising Bleeding Problems Bleeding Proble						Blood in Urine		
Muscular: Joint Pain		Urinary Incontinence						
Muscular: Joint Pain		N. 1. C				DI 1' D 11		
Muscular: Joint Pain	Heme:					Bleeding Problems		
Dermatologic: Rash Itching		Easy Bruising						
Dermatologic: Rash Itching	3.6 1	I : (D :				M 1 D ' /W 1		
Psych: Depression Unusual Stress Anxiety Diabetes Thyroid Disease Cancer: Yes No Pace Maker: Ves No Pace Maker: Diabetes Depression Unusual Stress Diabetes Thyroid Disease Pace Maker: Diabetes D	Muscular:	Joint Pain				Muscle Pain/Weakness		
Psych: Depression Unusual Stress Anxiety Diabetes Thyroid Disease Cancer: Yes No Pace Maker: Ves No Pace Maker: Diabetes Depression Unusual Stress Diabetes Thyroid Disease Pace Maker: Diabetes D	D (1)	D 1				11.		
Psych: Depression Unusual Stress Anxiety Endocrine: Diabetes Ves No Pace Maker: Depression Unusual Stress Diabetes Thyroid Disease Thyroid Disease Pace Maker: Ves No	Dermatologic:					Hives		
Unusual Stress Anxiety Endocrine: Diabetes Thyroid Disease Cancer: Yes No Pace Maker: Yes No Pace Maker: Difficulty Sleeping Thyroid Disease		Itching						
Unusual Stress Anxiety Endocrine: Diabetes Thyroid Disease Cancer: Yes No Pace Maker: Yes No Pace Maker: Difficulty Sleeping Thyroid Disease	D1	Danner.'				Classica 1 1 1		
Anxiety Endocrine: Diabetes No Pace Maker: Yes No	Psych:							
Endocrine: Diabetes						Difficulty Sleeping		
Cancer: Yes \square No \square Pace Maker: Yes \square No \square		Anxiety						
Cancer: Yes \square No \square Pace Maker: Yes \square No \square		7.1						
Pace Maker: Yes \square No \square	Endocrine:	Diabetes				Thyroid Disease		
Pace Maker: Yes \square No \square	Concer	Voc No						
	Cancer.	162 INO						
Name: Date:	Pace Maker:	Yes □ No □						
Name: Date:								
Name: Date:								
Name: Date:	N T				D :			
	name:				Date:			