WESTERN ORTHOPEDICS & SPORTS MEDICINE
Enhancing & Restoring Active Lifestyles

REGISTRATION FORM

Preferred Pharmacy:

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Today's Date:	**Who is your Primary Care Physician?**

Last Name:	**First:**	**Middle:**	**Marital Status (circle one)** Single / Mar / Div / Widow

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**Social Security #:**	**Birth Date:** / /	**Age:**	**Gender** ❑ M ❑ F

Street Address:	**P.O Box#:**	**Employer Information**	
		Employer:	**Employer Phone #:** ( )

City:	**State:**	**Zip Code**	**Employer Address:**		
Home Phone #: ( )	**Cell Phone #** ( )		**City:**	**State:**	**Zip Code**

OTHER INFORMATION

Referred to clinic by (please check one box):	**Email Address:**	
❑ Family ❑ Friend ❑ Close to my home/work		
❑ Website ❑ Yellow Pages	**Preferred Language:**	
❑ Dr. ❑ Hospital :	**Race:**	**Ethnicity:**

BILLING & INSURANCE INFORMATION

Person Responsible for Bill:	**Birth Date:** / /	**Address (if different):**	**Home Phone #:** ( )

Is this person a patient here? ❑ Yes ❑ No

Employer:	**Employer Address:**	**Employer Phone #:** ( )

Name of *Primary* Insurance:	**Phone #:**		**Policy/Claim #:**
Subscriber's Name:	**Subscriber's S.S.#:**	**Birth Date:** / /	**Group #:**

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of *Secondary* Insurance (if applicable):	**Phone #:**		**Policy/Claim #:**
Subscriber's name:	**Subscriber's S.S.#:**	**Birth Date:** / /	**Group #:**

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

IN CASE OF EMERGENCY CONTACT

Name:	Relationship to Patient:	Home Phone #: ( )	Work Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Western Orthopedics and Sports Medicine to release any information required to process my claims.

Patient/Guardian signature *Date*

Have you received the Flu Vaccine this year? **Yes** **No** **If Yes, When?** ______________________

Height: ___________ **Weight:** __________

Occupation: __________________________ **or (check one)**: ❑ Unemployed ❑ Disabled ❑ Student

What **body part** are you being seen for today? ____

When did your problem **start? (If specific date is unknown, please estimate the month and year):**

____

Was this the result of: ❑ Injury ❑ Sports ❑ Work Related ❑ Motor Vehicle Accident?

❑ Chronic Overuse ❑Other (Specify):____

Please describe your problem: ____

____

Where did it occur? ❑ At Home ❑ Work ❑ School ❑ Playing a Sport

❑ Other (Specify):______________________________________

Please circle the items below that best describe your problem:

What are your **current symptoms?** Pain Numbness Tingling Popping Crepitus Grinding Instability Locking Catching Bruising Swelling Weakness Decreased Range of Motion Giving Away Other (Specify):
Your Symptoms occur: Constantly Intermittently During Activity At Rest At night
Since the problem began, symptoms are: Worse Unchanged Improving
Severity of pain: No Pain Mild Moderate Severe Extremely Severe Mild to moderate Moderate to Severe
What is the **quality** of your Pain? Dull Sharp Aching Stabbing Throbbing Burning Other (Specify):
What **improves** your symptoms? Nothing Rest Ice Heat Elevation Compression Splint Immobilization Medication Bracing Other (Specify):
What makes your symptoms worse? Inactivity Motion Work Exercise Other (Specify):
Treatments utilized for problem: Bracing Injection Medication Physical Therapy Ice Heat Exercise Decreased Activity Crutches Cane Walker Other (Specify):
Pertaining to this problem you are being seen for today, have you had any: ❑ X-Rays ❑ MRI ❑ CT ❑ EMGs. ❑Other (Specify): **If so, Where (Hospital/Clinic) and When:**

Allergies (Medication or Enviromental) Please List Below: □ **No known drug allergies** □ **No known allergies**

Latex Allergy: ❑Yes ❑ No Reaction: ________________________________

Allergy:_____________________________ Reaction:________________________________

Allergy:_____________________________ Reaction:________________________________

Allergy:_____________________________ Reaction:________________________________

Allergy:_____________________________ Reaction:________________________________

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Western Orthopedic &Sports Medicine

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MEDICATION LIST

PLEASE INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICINE, SUPPLEMENTS, VITAMINS, ETC.

NAME:__________________________________**DOB:**__________________**DATE:**_________________

PREFERRED PHARMACY:____

MEDICATION NAME	DOSAGE	DIAGNOSIS (Why are you taking this medication?)