Western Orthopedics & Sports Medicine
Enhancing & Restoring Active Lifestyles

Registration Form

Today's Date:

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Last Name:	First:	Middle:	Birth Date: / /
Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Social Security #:	Home Phone: ( )
Cell Phone: ( )			
Street Address:	P.O. Box #:		
City:	State:	Zip Code:	
Marital Status (circle one): Single ◯ Married ◯ Divorced ◯ Widowed ◯	Gender: ◯ Male ◯ Female		

Employer Information

Employer:	Employer Phone #:
Employer Address:	
City:	State: / Zip Code:

Who is your Primary Care Physician?

OTHER INFORMATION

Referred to clinic by (please check one box):

◯ Dr. _____ ◯ Friend ◯ Website
◯ Yellow Pages ◯ Close to my home/work
◯ Family ◯ Hospital: _____

Email Address:

Preferred Pharmacy:

Preferred Language: | **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 #: ( )	Cell 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***

Patient Name: _____ **DOB:** _____

Height: _____ **Weight:** _____

Have you had any of the following? If 'yes' please provide a date.

Colonoscopy? _____ **Pneumonia vaccine?** _____ **Flu vaccine?** _____

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 ☐ Sleep disturbance due to pain ☐ 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 ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe ☐ Extremely Severe

What is the quality of your pain? ☐ Dull ☐ Sharp ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Burning
Other (Specify): _____

What makes your symptoms worse? ☐ Inactivity ☐ Motion ☐ Work ☐ Exercise
Other (Specify): _____

Treatments utilized for problem: ☐ Bracing ☐ Splint ☐ Injection ☐ Medication ☐ Physical Therapy ☐ Ice
☐ Heat ☐ Exercise ☐ Decreased Activity ☐ Crutches ☐ Cane ☐ Walker Other (Specify): _____

Pertaining to the 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 (Medications or Environmental) Please List Below:

☐ **Latex Allergy. If yes, list reaction:** _____ ☐ **No known drug allergies** ☐ **No known allergies**

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

IF YOU HAVE MORE ALLERGIES THAN THERE IS SPACE AVAILABLE, PLEASE CONTINUE TO LIST ON YOUR MEDICATION SHEET.