ORTHOPEDIC AND SPORTS ENHANCEMENT CENTER, LLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S NAME (LAST)	(FIRST)	(MI)	TODAY'S DATE

STREET ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE NUMBER

SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	MARITAL STATUS
			○ M ○ F	○ S ○ M ○ W ○ D

☐ STUDENT	NAME OF SCHOOL /COLLEGE	DO YOU CARRY INSURANCE THROUGH THE SCHOOL ○ YES OR ○ NO	CELL PHONE NUMBER

☐ EMPLOYED	EMPLOYER	Occupation	WORK PHONE NUMBER

NAME OF PHYSICIAN WHO REFERRED YOU TO SPORTS ENHANCEMENT CENTER	EMAIL ADDRESS

FAMILY PHYSICIAN (FIRST & LAST NAME, ADDRESS)

EMERGENCY CONTACT PERSON NAME	PHONE NUMBER

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

HUSBAND/FATHER'S NAME	STREET ADDRESS	CITY, STATE, ZIP CODE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE NUMBER

EMPLOYER	EMAIL ADDRESS	WORK PHONE NUMBER

WIFE/MOTHER'S NAME	STREET ADDRESS	CITY, STATE, ZIP CODE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE NUMBER

EMPLOYER	EMAIL ADDRESS	WORK PHONE NUMBER

INSURANCE OR WORK COMP(IF WORK COMP, PLEASE ASK FOR THAT FORM)

PRIMARY INSURANCE		SECONDARY INSURANCE	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
POLICY NUMBER		POLICY NUMBER	
GROUP NUMBER	PHONE NUMBER	GROUP NUMBER	PHONE NUMBER

PLEASE READ AND SIGN THE FOLLOWING

I hereby give my consent to Sports Enhancement Center to use or disclose, for the purpose of carrying out treatment, payment, or health care operation, all information contained in the above patient record. I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

It is the insured's responsibility to contact their insurance company to obtain pre-approval, if required, by their insurance company for services rendered and to contact Sports Enhancement Center as to what their policy covers. The insured understands and agrees to pay for any charges incurred that have not been paid by their insurance company, including co-pays, deductibles and all non-covered items beyond required write-offs. The insured further understands and agrees to pay any attorney and/or collection fees in the event that the account is referred on for collection.

Signature_____ Date_____

If you are not the patient, please specify your relationship to the patient_____

Notice of Privacy Practices

By signing below, I hereby acknowledge that I have been offered/received a copy of Sports Enhancement Center's Notice of Privacy Practices, effective April 14, 2003.

As of 7/01/2008, if we need to contact you for medical reasons we will utilize all numbers provided unless you follow the protocol as described per our notice of privacy practices (page 5, item 4 of Your Rights):

> "You have the right to ask that we inform you of medical matters in a certain way or at a certain location. To ask for private communications, you must provide a written request and inform us how or where you wish to be contacted. You do not need to inform us as to why. We will try to honor all reasonable requests, For example, you may request we only contact you via work or through mail."

The above policy supersedes all prior forms regarding communication as the policy has been in effect since April 14, 2003.

Signature:_____ Date:_____

Patient Name: _____

Please provide us with phone numbers we may use to contact you. If you wish for us to leave messages on an automated system or with others, please indicate to whom we can speak with.

Phone number/s _____,_____,_____

Person's with whom we may leave messages:_____

_____

May we leave messages on voice mail? Yes☐ No☐

ORTHOPEDIC & SPORTS ENHANCEMENT CENTER

An Affiliate of Advocate BroMenn

HEALTH HISTORY FORM

This is a confidential record and will be kept in our office. Information contained here will not be released to anyone without your authorization to do so.

NAME, (LAST, FIRST, MI)	TODAY'S DATE
DATE OF BIRTH	REFERRING PHYSICIAN

HISTORY OF PRESENT COMPLAINT: APPROXIMATE HEIGHT_____ WEIGHT_____

WHY ARE YOU HERE TODAY?
SEVERITY OF PAIN: Scale 1-10 (1 being None, 10 being Worst Manageable)
PROBLEM FIRST NOTICED WHEN:
WHAT MAKES IT WORSE OR BETTER?
HOW LONG DOES IT LAST?
HAVE YOU HAD RECENT X-RAYS? ☐ YES ☐ NO — IF SO, WHERE WERE THEY TAKEN?
ARE YOU CURRENTLY BEING TREATED FOR THIS ILLNESS/INJURY BY ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF YES, WHAT TREATMENT HAS BEEN DONE? (MEDS, THERAPY, ETC.)

MEDICAL HISTORY

MEDICAL PROBLEMS: LIST ALL YOU HAVE/HAVE HAD: (DIABETES, HYPERTENSION, CANCER, GLAUCOMA, HEART ATTACK, BLOOD CLOTS, ETC.)

☐ NONE

MEDICATIONS:

LIST PRESCRIPTIONS, OVER THE COUNTER MEDS AND HERBAL REMEDIES:

MIGHT YOU BE PREGNANT? ☐ YES ☐ NO

LIST ALL SURGERIES WITH APPROXIMATE DATES:

☐ NONE

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS, LATEX, RUBBER, OR X-RAY CONTRAST? ☐ YES ☐ NO

IF YES, PLEASE LIST ALLERGY (INCLUDING TYPE OF REACTION):

DO YOU DRINK ALCOHOLIC BEVERAGES? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO IF SO, HOW MANY PACKS? _____

HAVE YOU EVER SMOKED? ☐ YES ☐ NO IF SO, HOW MANY PACKS? _____

IF YES, WHEN DID YOU QUIT? _____

FAMILY HISTORY

LIST ANY SIGNIFICANT FAMILY HISTORY (DIABETES, HEART DISEASE, CANCER, HYPERTENSION, BLOOD CLOTS, ETC.)

☐ NONE

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Do you have fever, chills, headache, general tiredness, or weakness?	☐ YES	☐ NO
INTEGUMENTARY: Do you habe any skin rashes, persistent itching orother skin problems?	☐ YES	☐ NO
EYES: Do you have any blurred vision, double vision, blind spots, glaucoma, or eye pain?	☐ YES	☐ NO
ENT: Do you have any chronic or persistent ear, sinus, or throat infections or problems?	☐ YES	☐ NO
CARDIOVASCULAR: Do you have any history of chest pain/angina, high blood pressure,or heart murmurs?	☐ YES	☐ NO
PULMONARY: Do you have any history of persistent cough, wheezing, shortness of breath, or pneumonia?	☐ YES	☐ NO
GASTROINTESTINAL: Do you have any chronic nausea, vomitting, indigestion, heartburn, or stomach pains?	☐ YES	☐ NO
MUSCULOSKELETAL: Do you have any history of back, neck or joint pain or injury?	☐ YES	☐ NO
NEUROLOGICAL: Do you have any history of tremors, dizzy spells, numbness, or tingling?	☐ YES	☐ NO
ENDOCRINE: Do you have any history of excessive thirst, weight loss/gain, or too hot/too cold?	☐ YES	☐ NO
HEMATOLOGICAL: Do you have any history of swollen glands, excessive bleeding, or blood clots?	☐ YES	☐ NO
PSYCHOLOGICAL: Do you have any history of depression, anxiety attacks, or suidical thoughts?	☐ YES	☐ NO

PROVIDER'S NOTES:

DATE: _____ PHYSICIAN'S SIGNATURE: _____

WHEN COMPLETE, EMAIL FORM TO ADMIN@OSECMAIL.COM