CENTRAL ILLINOIS ORTHOPEDIC SURGERY, II LLC.

Also d/b/a NEURO ORTHO REHAB CENTER

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PATIENT INFORMATION

Please Print

Name: ______________________ DOB: ____________ Today's Date: ____________

Address: ______________________ City, State, Zip: ______________________

Home Phone #: ____________ Work Phone #: ____________ Cell Phone #: ____________

SS#: ____________ Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Child

Primary Care Physician: ____________ Referred By: ☐ Physician ☐ ER ☐ Patient ☐ Attorney ☐ Insurance ☐ Newspaper ☐ Yellow Pages ☐ Website ☐ Other

Spouse/Parent/Guardian Name: ____________ DOB: ________ Employer: ____________

Address (if different): ______________________ Phone (if different): ____________

Emergency Contact: ____________ Phone #: ____________ Address: ____________

Emergency Contact Relation: ____________ Driver's License #: ____________

Email Address: ______________________

EMPLOYMENT INFORMATION

Occupation: ______________________ Employer: ______________________

Employer Address: ______________________ Employer Phone #: ____________

INSURANCE/BILLING INFORMATION

Guarantor (If Other Than Patient) ______________________ Relationship: ____________

Billing Address: ______________________ Phone #: ____________

Primary Insurance: ______________________ Address: ______________________

Phone #: ____________ Insured's Name: ____________ Relationship to Patient: ____________

Insured's SS#: ____________ Insured's DOB: ____________ Group #: ____________

Secondary Insurance: ____________ Address: ____________

Phone #: ____________ Insured's Name: ____________ Relationship to Patient: ____________

Insured's SS#: ____________ Insured's DOB: ____________ Group #: ____________

Please have your insurance card with you, as we will need to make a copy of them.
You are responsible for all charges until your insurer has made payment.

PATIENT'S ORTHOPEDIC HISTORY

List all Medications you are now taking (include those you take without a prescription).

Medication	Dose	Reason	Medication	Dose	Reason

Allergies:____________

Do you take Vitamins or Supplements? Yes___ No___ If yes,
List:____________

Do you smoke? Yes__ No___ If Yes, Number of Cigarettes or Packs per Day:____________
Have you quit smoking? Yes__ No__ If Yes, 1 Year___ 5 Years___ 10 Years___
Do you drink alcohol? Yes__ No__ If Yes, Daily___ 1-2 x/week___ 1-2 x/month___ 1-2 x/year___
Do you take Recreational Drugs? Yes___ No___ If yes, List:____________

Review of Systems Are you currently having or have you had problems with your:

Eyes Yes__ No__ Blackout/Fainting/Dizziness Yes__ No__ Balance Problems Yes__ No__
Ears, Nose, Throat Yes__ No__ Psychological Problems Yes__ No__ Numbness/Tingling Yes__ No__

Lungs, Breathing Yes__ No__ AIDS Yes__ No__ Bleeding Problems Yes__ No__
Digestion Yes__ No__ Cancer Yes__ No__ Stomach Ulcers Yes__ No__
Bowel Movement Yes__ No__ Arthritis Yes__ No__ Liver Disease Yes__ No__
Bladder Problems Yes__ No__ Stroke/Seizure/Disorders Yes__ No__ Kidney Disease Yes__ No__
Diabetes Yes__ No__ Cardiovascular Condition Yes__ No__ CHF Yes__ No__
High Blood Pressure Yes__ No__ Musculoskeletal Problems Yes__ No__
List Other Problems____

Past Medical History ____

List Surgical Procedure (s) Year Complications

________________________________ ______ ______________________

________________________________ ______ ______________________

________________________________ ______ ______________________

________________________________ ______ ______________________

Have you ever had general anesthesia? Yes__ No__ Any problems with anesthesia? Yes__ No__

If yes to any problems, describe:____

HISTORY OF PRESENT ILLNESS

Please describe your problem(s) (chief complaint) ?
____

How long has this bothered you? ________________ Have you seen a Physician for this problem: Yes\No
If Yes, Who previously treated you:____

Describe treatment:____
Any Tests Performed? Yes__ No__ If yes, do you have them with you? Yes__ No__

DESCRIBE SYMPTOMS

Rate Discomfort (circle one): None = 1 2 3 4 5 6 7 8 9 10 = Severe

Location (check all that apply): Groin___ Buttocks___ Knee___ Hip___ Shoulder___ Foot/Ankle___
Leg above the Knee___ Leg below the Knee___ Upper Extremity___
Neck___ Mid-Back___ Lower Back___
Other____

Quality (check all that apply): Sharp__ Dull__ Burning__ Throbbing__ Tingling__ Constant__ Intermittent__

Associated Symptoms: Stiffness___ Where? ____

(check all that apply) Numbness___ Where? ______
Swelling___ Where? ______
Catching___ Where? ______
Weakness___ Where? ______

When do symptoms occur? Walking__ Running__ Stairs__ Rising from Chair__ Night__ Morning__
At Work__ During Exercise__ After Exercise__ Other______

What makes symptoms better? Rest__ Therapy__ Heat__ Cold__ Brace/Bandage__ Walking Aid__ Exercise__
Medication______Other______

Pain in other joints? Yes__ No__ List:______
Do you use support? Yes__ No__ 1 Cane__ 2 Canes__ 1 Crutch__ 2 Crutches__ Walker__

If this is a Workers' Compensation Claim, please fill out History of Injury on the following page.

WORKERS' COMPENSATION HISTORY OF INJURY/AGREEMENT

Description of Condition: ______

What **date** did your injury occur? (Be as specific as possible): ______

Where did your injury occur? (Be as specific as possible): ______

______

How did your injury occur? (Be as specific as possible): ______

______

Were there any witnesses to your injury? □ Yes □ No If so, who? ______

Did you report this incident to your employer? □ Yes □ No If so, to whom? ______

What **date** did you report the incident to your employer? ______

What **date** were you first evaluated and/or treated for this medical condition? ______

Have you stopped working as a result of the injury? □ Yes □ No Date you stopped working: ______

ı still off work due to the injury? □ Yes □ No

Have you ever had a similar medical problem or injury? □ Yes □ No If yes, when? ______

If you have had a similar medical problem or injury, please describe: ______

______

Please list below ANY treatment you have received for this condition:

Who treated you?	Date of service?

Workers' Compensation Carrier: ______________________________

Workers' Compensation Carrier Address: ______________________________

Workers' Compensation Carrier Phone #: ______________________________ Claim #: ____

Have you retained an attorney? ◻ Yes ◻ No If yes, attorney's name: ______________________________

Attorney's address:

Phone ________________

Any other information that would be useful in filing your claim: ______________________________

I testify that my injuries are the direct result of the above described incident. I understand that I am responsible for any charges incurred due to the treatment of my medical condition. In addition, I also understand that Central Illinois Orthopedic Surgery II, L.L.C. (CIOS), also d/b/a Neuro Ortho Rehab Center, will make a diligent attempt to retrieve payment for services provided to me from the workers' compensation insurance company in cases that have been deemed to be covered by workers' compensation insurance. If my case is not deemed to be covered by workers' compensation insurance, I understand I am expected to follow the guidelines set forth in the "Payment Agreement/Consent/Assignment/Release" section of this form. Finally, I understand that should the settlement for my workers' compensation case take longer than 6 months to resolve, CIOS will expect my account to be paid in full within 30 days of the first statement I receive requesting payment on my account unless other arrangements for payment are approved by CIOS in writing.