



Patient Registration Form

(Please Print Clearly)

15041 S. Vandyke Rd Suite 101
Plainfield IL 60544
Phone 815-267-8596
Fax 815-828-0965
PainAndWellnessGroup.com

PATIENT INFORMATION

Name: _____		Date of Birth: _____	
Address: _____		Home Phone: _____	
City, St: _____	Zip: _____	Mobile Phone: _____	
Soc. Sec. #: _____		Email: _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____ Weight: _____

WORK INFORMATION

Employer: _____		Work Phone: _____	
Address: _____		Job Description: _____	
City, St: _____	Zip: _____	_____	

INJURY INFORMATION

Car Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No
Work Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMERGENCY CONTACT

Name: _____
Home Phone: _____
Mobile Phone: _____

DEMOGRAPHIC INFORMATION

Race:	<input type="checkbox"/> American Indian or Alaskan Native
	<input type="checkbox"/> Asian <input type="checkbox"/> Other
	<input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander
	<input type="checkbox"/> Caucasian <input type="checkbox"/> Decline
Ethnicity:	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline

HOW DID YOU FIND US?

<input type="checkbox"/> Referral	Name: _____
	Phone: _____
<input type="checkbox"/> Phone Book	
<input type="checkbox"/> Internet	Please explain: _____
<input type="checkbox"/> Other	Please explain: _____

PRIMARY INSURANCE INFORMATION (or check here for Cash Only)

Insurance Name: _____	Policy #: _____	Group #: _____
Insured is: <input type="checkbox"/> Self <input type="checkbox"/> Spouse* <input type="checkbox"/> Parent* <input type="checkbox"/> Other* _____ (*if not Self, please complete next two rows)		
Name of Insured: _____	Date of Birth: _____	
Soc. Sec. #: _____	Employer: _____	

SECONDARY INSURANCE INFORMATION

Insurance Name: _____	Policy #: _____	Group #: _____
Insured is: <input type="checkbox"/> Self <input type="checkbox"/> Spouse* <input type="checkbox"/> Parent* <input type="checkbox"/> Other* _____ (*if not Self, please complete next two rows)		
Name of Insured: _____	Date of Birth: _____	
Soc. Sec. #: _____	Employer: _____	

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurances and any other health plans to: Pain and Wellness Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____ Date _____

If Minor, Signature of Responsible Party: _____ Date _____



Request for Confidential Communication

15041S. Vandyke Rd Suite 101
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PainAndWellnessGroup.com

I, _____, hereby request Pain and Wellness Group Ltd.
(Print Patient's Name)
to keep all communications regarding my protected health information confidential. To accomplish this request, please adhere to the following requests:

PHONE

You may contact me by phone at the following numbers:

- Home Phone _____
- Mobile Phone _____
- Work Phone _____

You may leave messages on my answering machine: Yes No N/A

You may leave messages on my voice mail: Yes No N/A

You may leave messages with another person: Yes* No N/A

*If Yes, please provide names of approved people: _____

MAIL

You may send mail to me at:

Address: _____
City: _____
State: _____
Zip: _____

EMAIL

You may send email to me at:

FAX

You may send faxes to me at:

Other Requests for Confidential Communications: _____

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Signature: _____ Date: _____

Date of Birth: _____

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

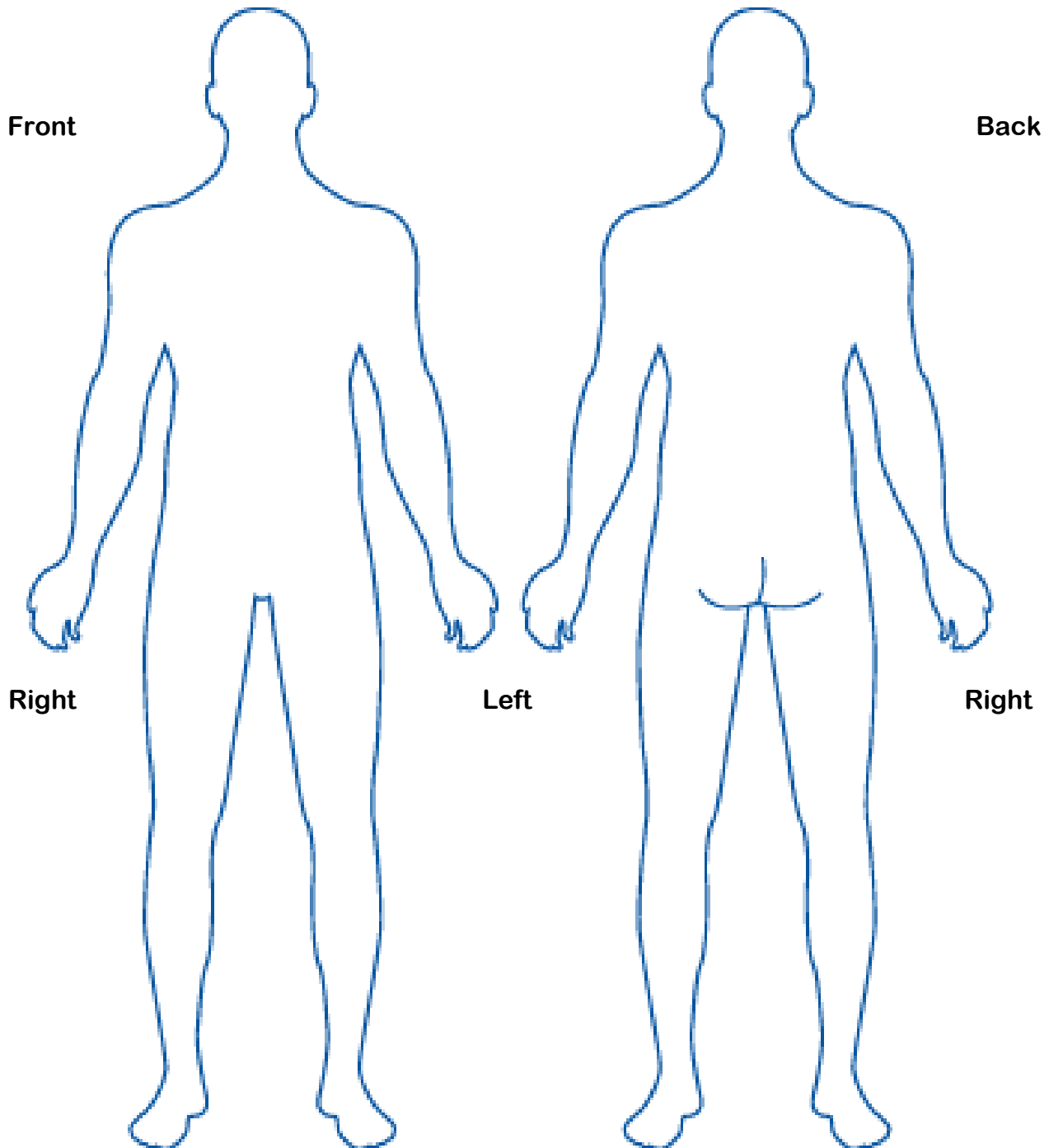


Pain Location Diagram

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DIRECTIONS

Mark the most severe pain areas with "XXXXX"
Mark moderate pain areas with "OOOOO"



Patient Signature: _____ Date: _____

Symptom Checklist

Patient Name : _____

Date of Birth : ____/____/____

Patient Signature : _____

Today's Date : ____/____/____

Please indicate which of the following symptoms you experience:

Symptom	Side of the Body			
	Right	Left	Both	None
Back and Leg Pain				
Pain in your lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in your buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or burning in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of strength in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Pain				
Pain or burning in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feels like pins and needles in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sensitivity to touch on your feet (for example, it hurts when bed covers touch them)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling hot or cold in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling your feet when you walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort or pain at night in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand, Finger or Wrist Pain				
Pain or burning in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gripping things with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty forming a fist with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort in hands wakes you at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus				
Do you have diabetes?	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	<input type="checkbox"/> No	
How long have you had diabetes?	_____			

Office Use Only
Clinical Assessment
Confirmed : <input type="checkbox"/> Yes <input type="checkbox"/> No
Exam Notes : _____ _____ _____
Confirmed : <input type="checkbox"/> Yes <input type="checkbox"/> No
Exam Notes : _____ _____ _____
Confirmed : <input type="checkbox"/> Yes <input type="checkbox"/> No
Exam Notes : _____ _____ _____
Eye Exam Notes : _____ _____ _____

Clinician Use Only	
Date of last documented dilated eye exam ____/____/____ <input type="checkbox"/> None	Schedule RIS Date _____
Clinician Review _____	Schedule NCS Date _____



Patient History

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Name: _____

Date of Birth: _____

MEDICAL HISTORY

Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Small Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lumbago	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No

High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GI Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autoimmune Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Current Medications: _____

Allergies or Intolerances: _____

Surgeries: _____

Date of Last Physical Exam: _____

Other Significant Conditions? Yes No

If Yes Describe: _____

SOCIAL HISTORY

Marital Status: Married Single Widowed Divorced Engaged In a Relationship

Children: Sons? Yes No Ages: _____

Daughters? Yes No Ages: _____

Work Status: Full Time Part Time Unemployed Retired Student Homemaker

Nutritional Habits: _____

Exercise (How Much? How Often? What Type?): _____



Patient Rights and Responsibilities

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Pain and Wellness Group (PWG) is committed to providing accessible, quality health care to all patients that come to the PWG clinic for treatment and other health care needs. Our goal is to ensure that staff treats each person with dignity, respect and that each patient understands their rights and responsibilities.

PATIENT RIGHTS

1. Know that all information in your chart or records will be treated in a confidential way by all staff of PWG unless you have given permission for the release of your medical information or reporting is required or permitted law. The staff includes full-time, part-time, temporary or volunteer staff and consists of nurses, physicians, billing, and administrative personnel.
2. Know at all times that you can register complaints or discuss concerns with our Office Manager.
3. Know that you will not be excluded from receiving services based on the grounds of sex, sexual orientation, national origin, race, religion, ethnicity or economic status.
4. Know that you have the right to be free from mental and physical abuse and that your civil rights will be respected.
5. Know that you have the right to discuss with your provider all decisions regarding the furnishing of care, denial or changes in service. If you are ineligible for services, a written record of your concerns and the reason for the decision will be placed in your records by your provider.
6. Know you will receive open and honest communication from your provider.

PATIENT RESPONSIBILITIES

1. To maintain open and honest communication with your provider at all times.
2. To keep all scheduled appointments or cancel by calling Pain and Wellness Group at (815) 267-8596 to reschedule no less than twenty-four hours in advance. Failure to provide at least twenty-four hour notice will give Pain and Wellness Group the right to either accept or deny you as a patient in any of the facilities.
3. To strictly adhere to your medications schedule as prescribed by your provider. Please note that refill scripts will only be written in person at the time of your appointment with the doctor and will not be granted prior to your preset refill date regardless of your specific circumstance. (Faxed requests from the pharmacy will not be refilled unless prior arrangements have been made with your provider)
4. To inform your provider of any significant changes in your condition: Physical, social, etc.



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PATIENT RESPONSIBILITIES (Cont.)

5. To actively participate in your treatment plan, being careful to follow the doctor's prescribed orders and asking questions to clarify expectations. You should cooperate fully with providers in complying with mutually accepted treatment regimens and regularly reporting on treatment progress. If serious side effects, complications, or worsening of the condition occur, you should notify your providers promptly. In addition, you should also inform your providers of other medications and treatments you are pursuing simultaneously with other medical providers.
6. As many treatment plans are scheduled in advance, please understand your condition will not progress as expected if you are missing appointments or treatments. If you feel that you need to discontinue care at PWG for any reason, please discuss this with the Doctors so that a discharge from care order may be given.
7. To become knowledgeable about your health plan. You should read and become familiar with the terms, coverage provisions, rules, and restrictions of your health plans. You should not be hesitant to inquire with appropriate sources when additional information or clarification is needed about these matters.
8. To maintain your financial obligations with Pain and Wellness Group as agreed. Payment for services rendered will be required prior to your scheduled appointment. This includes co-payments, cash payments, and all other financial arrangements that have been mutually agreed upon by you and an approved member of the Pain and Wellness Group financial staff.
9. To pursue healthy lifestyles. You should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, you should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.
10. To honor the Doctor's time by limiting your questions for the Medical staff to the time of your appointment. (This includes but is not limited to refill requests) With the office functioning in an open concept setting, while the doctor may be visible, he may not be available for additional questions. Honoring the Doctors time will insure our ability to function in an efficient and effective manner at all times.

MUTUAL RESPECT AND COOPERATION WILL ENSURE A PRODUCTIVE RELATIONSHIP

Patient Signature

Date

Print Name

PWG Representative

Date