LAWRENCE LI, MD
ORTHOPEDIC & SHOULDER CENTER
Minimum Invasion • Maximum Result

2200 Ft Jesse Rd, Suite 250
Normal, IL 61761
Phone: 309-888-9800
Fax: 866-888-9198

Child Registration Form

Account Number _____ Visit Date _____ Staff Initials _____

Patient Information

Legal Name	Preferred Name	Sex	Age
Mailing Address	Date of Birth	Social Security Number	
City,State, Zip Code	Are Parents Divorced? Yes: _____ No: _____	If yes, please explain custody: Mom: _____% Dad: _____%	

Parent Information

Mothers Name (Last, First, M.I.)		Father's Name (Last, First, M.I.)	
Mothers DOB	Last 4 digits Mother's SSN#	Father's DOB	Last 4 digits Fathers SSN#
Mother's Mailing Address (If different than patient's above)		Father's Mailing Address (If different than patient's above)	
Mother's City, State, Zipe Code (If different than patient's above)		Father's City, State, Zip Code (If different than patient's above)	
Mothers Home Phone	Mother's Cell Phone	Father's Home Phone	Father's Cell Phone
Mother's Employer	Mother's Work Phone	Father's Employer	Father's Work Phone

Primary Insurance Information

Name of Insurance Company			Policy Number
Name of Insured	Relationship to patient	Subscriber DOB	Group Number
Mailing Address of Insurance Company			Copay Amount $ / Deductible Amount $
City,State, Zip Code			Effective Date / Expiration Date

Secondary Insurance Information (if applicable)

Name of Insurance Company			Policy Number
Name of Insured	Relationship to Patient	Subscriber DOB	Group Number
Mailing Address of Insurance Company			Copay Amount $ / Deductible Amount $
City,State, Zip Code			Effective Date / Expiration Date

Referring and Primary Care Physician Information

Physician who referred you	Primary Care Physician

How did you hear about us (if not referred by another physician)

1) Yellow pages 2) Internet 3) Insurance Referral 4) Personal Referral _____ 5) Other _____

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Medical History Form

Account Number _____ Visit Date _____ Staff Initials _____

Patient Information

Name	Date of Birth	Height	Weight

Medical Conditions

Please check if you have a history of the following:

Asthma _____	Insulin Diabetes ☐ Non-Insulin Diabete ☐	Emphysema ☐	Urinary Tract Infection _____	Arthritis _____	Gout ☐	HyperThyroid ☐ HypoThyroid ☐
Hypertension (High Blood Pressure) _____			Cancer (please specify) _____			
Do you use recreational drugs? Yes _____ No _____			If yes please specify _____			
Do you Smoke Tobacco? Yes _____ No _____			Do you drink alcohol regularly? Yes _____ No _____			

Please list any medical conditions you may have other than the ones states above: _____

_____

Please list all surgeries you have had: _____

_____

_____

Medications

Please list all medications, including over-the counter and herbals, with dosages, schedules, and reasons for currently taking them:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all allergies to MEDICATIONS and your reaction below

Are you allergic to Latex? Yes _____ No _____

_____

_____

Previous Treatments

Have you had any of the following Medical or Rehabilitative services for your current injury?

Xray _____	MRI _____	EMG/NCV _____	CT Scan ☐	Physical Therapy _____	Occupational Therapy ☐

If yes to any, please list when and where the procedure was performed: _____

IF YOU HAVE A LIST OF YOUR MEDICATIONS, PLEASE ASK THE RECEPTIONIST TO MAKE A COPY

Injury Details

Briefly describe what is injured:

Briefly describe how this injury occurred:

Job Title: | Main Job Duties:

Date that injury occurred: ____/____/_____ approx time _____ | Dates of work missed: ____/____/_____ through ____/____/_____

Did you report the injury immediately? Yes _____ No _____ | If so, to who?

Were you sent to a doctor/Emergency room as a result of this injury? Yes _____ No _____ | If so, name of doctor, clinic, or hospital where you were seen

Are you currently experiencing pain? Yes _____ No _____ | Is your pain? Sharp _____ Dull _____ Aching _____

Is your pain? Occasional _____ Frequent _____ Constant _____ | Mild _____ Slight _____ Moderate ____ Severe _____

Pain on a scale of 1-10 (10 being worst imaginable) is: _____ | Since the injury, the problem is : Worse ____ Better _____ Same ____

Check if you have any of the following symptoms

Numbness _____ Where _____ | Swelling _____ Where _____

Tingling _____ Where _____ | Popping _____ Where _____

Stiffness _____ Where _____ | Grinding _____ Where _____

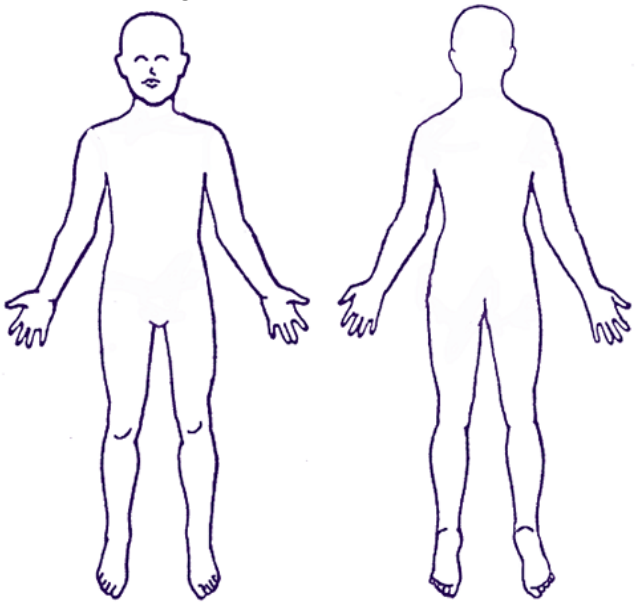
Weakness _____ Where _____ | Locking _____ Where _____

Giving Way _____ Where _____ | Deformity _____ Where _____

What makes the pain worse?

What makes the pain better?

Pain Drawing Grid Assessment



Please Mark the areas where you are experience the following sensations

Ache: ^^^^^^

Burning: XXXXX

Numbness: oooooo

Pins & Needles: ======

Stabbing: ///////

_____ _____

Signature of Patient/Responsible Party Date

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Consent Form

Consent to Treat: I request and give consent to my physician to provide and perform such medical and surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. If the patient is a minor I certify that I am the legal guardian of the minor, _____, and I authorize the physician to perform the procedures required for medical evaluation and treatment. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me.

Initials _____

Release of Medical Information and Authorization to Pay Benefits: I authorize my physician to release information from my medical record to my insurance carrier(s) or government agency for the processing of claims for medical benefits. I direct my insurance company (or companies) to honor this assignment of any and all rights to my insurance benefits applicable to the services provided and to pay all assigned insurance benefits directly to my physician, on my behalf. If the need for these services is related to a workers' compensation or a personal injury claim and my physician is so notified at the time services are provided, I understand and agree that any deficiency in payment to my physician will remain my responsibility to pay unless otherwise modified by Illinois Statute.

Initials _____

Medical Certification: I certify that the information given by me in applying for payment under title XVII of the Social Security Act is Correct. I authorize the physician who treats me to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers or to the Professional Standards Review Organization for processing of claims for medical benefits. I request that payment of authorized benefits be made directly to the physician treating me on my behalf.

Initials _____

Financial Agreement: I understand that all accounts are the responsibility of the patient and the patient's responsible party, guarantor, or parent(s). I further acknowledge and understand that the Family Expense Statute may be applicable and that my spouse may have liability for payment pursuant to the act. I acknowledge that the information provided by me is true and correct and that it has been furnished to this office with full knowledge that I am liable for all services rendered and that I am contractually bound to pay for said services. As a courtesy to me, my physician will assist me in obtaining insurance benefits by filing claims for services since I have assigned those benefits to my physician. I understand that it is my responsibility to respond promptly to any requests for information from my insurance carrier or my physician's office and failure to do so which results in the denial of the claim by my insurance carrier shall make me personally liable to the physician for such non-payment. I promise to pay collection costs, up to 50% of the balance owed to OSC, and reasonable attorney fees incurred to effect collection of this account.

Initials _____

_____ Date: _____/_____/_____

Signature of Patient/Parent/Guardian