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

**Third Party Liability Registration**

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 | Email Address | | |
| Home Phone / Cell Phone | Work phone | Marital Status | |

## Employment Information

| | |
|---|---|
| Employer/Occupation | Emergency Contact/Relationship |
| Employer's Local Address | Emergency Home/Cell Phone |
| City,State, Zip Code | Emergency Work Phone |

## Attorney Information (if applicable)

| | | |
|---|---|---|
| Attorney Name | Attorney Phone Number | Attorney Fax Number |

## Third Party Information

| | |
|---|---|
| Place where accident/injury occurred | Date of accident |
| Was this place informed of the accident immediately? Yes _____ No ____ | Who is responsible, other than health insurance, for payment? |
| Name of person handling this case | Phone & Fax number of person handling this case |

## Primary Health 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 Health 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 Diabetes ☐ | 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 _____

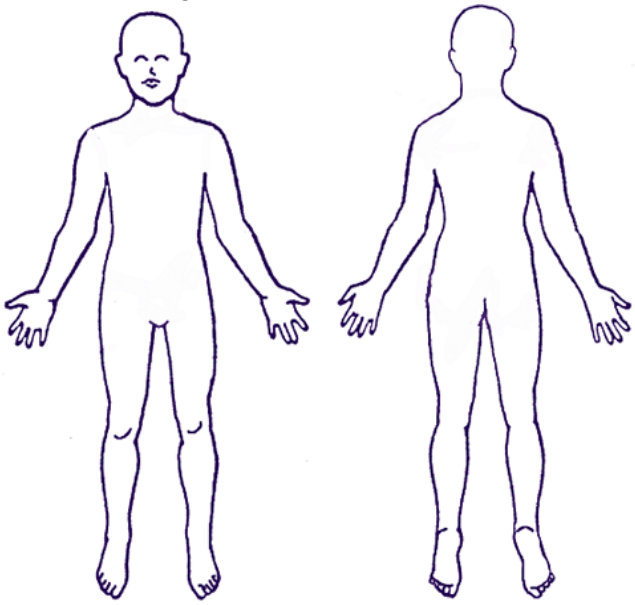
Weakness _____ Where _____ | Locking _____ Where _____

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