

PATIENT REGISTRATION
Please Complete Fully and Print Clearly

Patient's Name: _____
(First) (M.I.) (Last)

Date of Birth: _____ **Age:** _____ M F

Address: _____

Social Security #: _____

City: _____ **State:** _____ **Zip:** _____

Home Ph. #: _____ Prefer?

Cell Ph. #: _____ Prefer?

Occupation: _____

Work Ph. #: _____ Prefer?

Emergency Contact: _____

Relationship: _____ **Phone:** _____

Primary Language? _____ **Race:** _____

Decline? **Ethnicity:** _____ Decline?

How were you referred to the Jho Institute? (Check all that apply)

- Referring Physician (See below) Friend/Family www.drjho.com Other _____

PHYSICIAN INFORMATION

If referred by a physician, please list below:

Referring Physician: M.D. D.O. Other _____

Address: _____

Suite: _____ **City:** _____

State: _____ **Zip:** _____

Phone: _____ **Fax:** _____

Physician Specialty: _____

Please list any other physicians to whom you wish your records be sent:

Family Physician: M.D. D.O. Other _____

Address: _____

Suite: _____ **City:** _____

State: _____ **Zip:** _____

Phone: _____ **Fax:** _____

Physician Specialty: _____

Other Physician: M.D. D.O. Other _____

Address: _____

Suite: _____ **City:** _____

State: _____ **Zip:** _____

Phone: _____ **Fax:** _____

Physician Specialty: _____

RELEASE OF INFORMATION: I authorize the release of this medical record, any related studies, and other information to my family physician(s), the doctor to whom I am referred, my legal counsel, and to the applicable third-party payor.

Patient or Authorized Person: (Signature) _____

Date: _____

INSURANCE INFORMATION

Please list all insurances applicable for this visit:

Primary Insurance: _____

Policy/ID #: _____

Group #: _____

Subscriber Name: _____

Subscriber DOB: _____

Claim Address: _____

City: _____ **State:** _____ **Zip:** _____

Secondary Insurance: _____

Policy/ID #: _____

Group #: _____

Subscriber Name: _____

Subscriber DOB: _____

Claim Address: _____

City: _____ **State:** _____ **Zip:** _____

Was there an accident involved? Y N

If Yes: Work Related Auto Other _____

Work/Auto Ins.: _____

Policy/Claim #: _____

Date of Incident: _____ **State:** _____

Injured Body Part(s): _____

Employer/Auto Ins. Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer/Policy Holder: _____

AUTHORIZATION AND ASSIGNMENT OF

BENEFITS: I authorize payment of medical benefits per appropriate assignment(s) above to the physician or organization rendering services, not to exceed the balance due of any aforementioned provider's regular charges for this period of service.

Patient or Authorized Person: (Signature) _____

Date: _____

MEDICAL HISTORY
Please Print

Height: _____ Weight: _____ Date Of Onset: _____

Reason For Today's Visit: _____

Describe Present Condition: _____

List Previous Hospitalizations/Surgeries/Serious Injuries (Brain/Spine First)	When?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed
Use of Alcohol: Never Rarely Moderate Daily _____
Use of Tobacco: Never Previously But Quit _____ Months / Yrs Ago Current Packs Per Day _____
Are You On A Special Diet? No Yes What Type? _____
Are You Taking Aspirin? No Yes (Tablets/Day _____)
Is There A Possibility You Are Pregnant? Yes No
Have You Had A Recent Cold, Flu Or Infection (i.e.: dental, urinary)? Yes No

MEDICATIONS

List All Medications You Are Presently Taking, Dosage, And Length Of Time On Medication:

	Medication	Dosage/Times Per Day	How Long On Medication
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

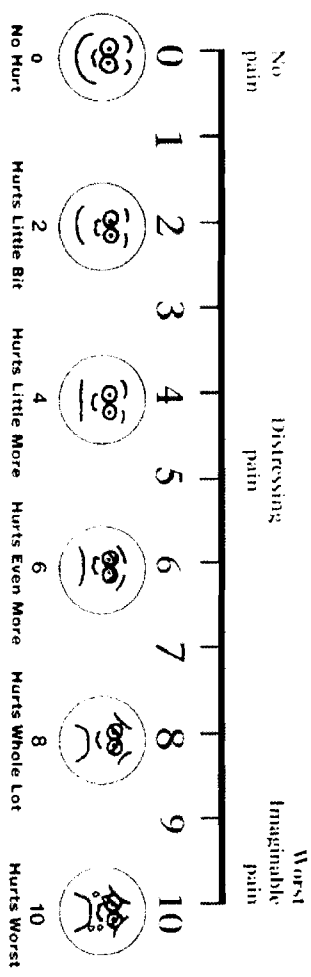
ALLERGIES

List All Allergies _____
And Your Reaction To Them: _____

Note: Please include any allergies or reaction to MRI or CT Imaging dyes

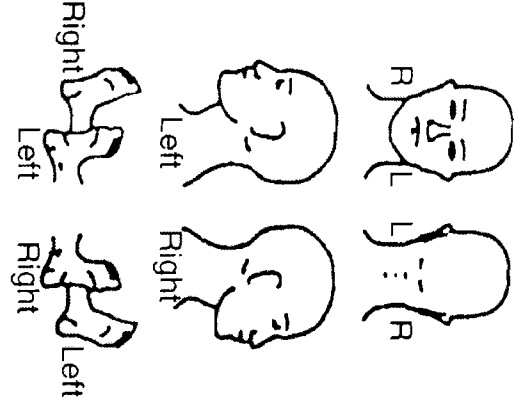
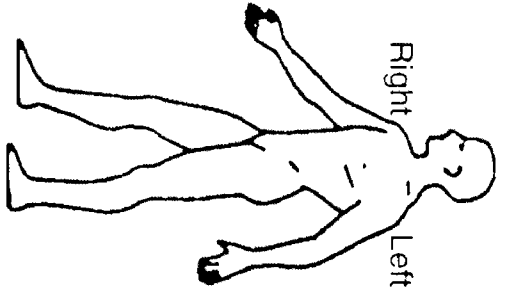
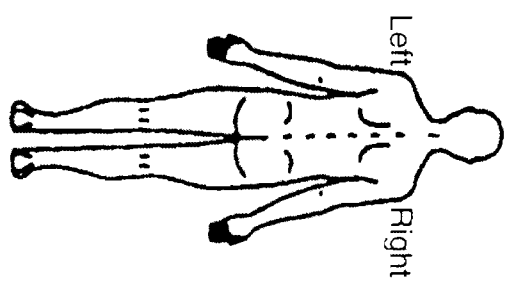
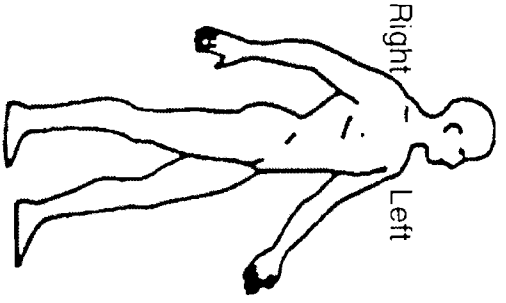
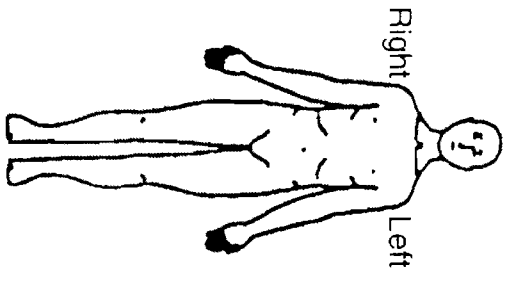
Date: _____

Wong-Baker Faces Pain Rating Scale©



Please mark the areas on your body where you feel the following sensations, using the symbol below:

- * NUMBNESS
- PINS/NEEDLES
- X BURNING
- / STABBING



MEDICAL HISTORY
Please Print

Do You Have A History Of (Check All That Apply):

- Abnormal Bleeding Explain: _____
- Cancer Explain: _____
- Diabetes Explain: _____
- Heart Disease Explain: _____
- High Blood Pressure Explain: _____
- Lung Disease or TB Explain: _____
- Rheumatoid Arthritis Explain: _____
- Stomach Problems Explain: _____
- Thyroid Disease Explain: _____
- Nervous Disorder Explain: _____
- Other _____ Explain: _____

Do You Have An Advanced Directive/Living Will: Yes No

Key Directives/Orders: _____

Complete Past, Family, & Social History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other	_____	_____	_____

Please Check Any Diseases Which Have Occurred In Any Of Your Blood Relatives:

- Abnormal Bleeding
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Lung Disease or TB
- Rheumatoid Arthritis
- Stomach Problems
- Thyroid Disease
- Nervous Disorder
- Other _____

Date: _____