



NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Legal Name: _____	Preferred Name: _____
Date of Birth: _____ Age: _____	Sex: ☐ Female ☐ Male ☐ Other
Address: _____	
City: _____	State: _____ ZIP: _____
Primary Phone: _____	Alternate Phone: _____
Email: _____	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	Preferred Language: _____
Social Security Number (optional): _____	Driver's License/ID: _____

EMERGENCY CONTACT

Name: _____	Relationship: _____
Phone: _____	Alternate Phone: _____

PRIMARY CARE AND REFERRAL INFORMATION

Primary Care Provider: _____	Phone: _____
Referring Provider: _____	Phone: _____
How did you hear about us? ☐ Provider ☐ Family/Friend ☐ Internet ☐ Insurance ☐ Other: _____	

PREFERRED PHARMACY

Pharmacy Name: _____	Phone: _____
Address/Location: _____ _____	

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company: _____	Member ID: _____
Group Number: _____	Policyholder: _____
Policyholder DOB: _____	Relationship to Patient: _____

**SECONDARY INSURANCE (if applicable)**

Insurance Company: _____	Member ID: _____
Group Number: _____	Policyholder: _____
Policyholder DOB: _____	Relationship to Patient: _____

GUARANTOR INFORMATION (IF DIFFERENT FROM PATIENT)

Name: _____	Relationship: _____
Address: _____	
Phone: _____	Date of Birth: _____

I certify that the information provided above is accurate and complete. I agree to notify the practice of any changes.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



COMPREHENSIVE MEDICAL AND PAIN INTAKE HISTORY

Patient Name: _____

Date of Birth: _____

Today's Date: _____

CHIEF COMPLAINT AND PAIN HISTORY

What is the main reason for today's visit?

When did the problem begin? _____

☐ Sudden onset ☐ Gradual onset ☐ Work-related ☐ Motor vehicle accident ☐ Personal injury ☐ Other

If injury-related, describe: _____

Pain location(s): _____

Does the pain travel/radiate? If yes, where?

Current pain: ____ /10	Best pain: ____ /10	Worst pain: ____ /10
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☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Electric ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other:

☐ Constant ☐ Intermittent ☐ Worse in morning ☐ Worse at night ☐ Wakes me from sleep

What makes the pain worse? _____

What makes the pain better? _____

☐ Numbness ☐ Tingling ☐ Weakness ☐ Balance difficulty ☐ Falls ☐ Bowel changes ☐ Bladder changes ☐ None

Describe associated symptoms: _____

EFFECT ON FUNCTION

☐ Walking ☐ Standing ☐ Sitting ☐ Sleeping ☐ Work ☐ Exercise ☐ Household activities ☐ Personal care

How far can you walk? _____

How long can you sit? _____

How long can you stand? _____

PREVIOUS EVALUATION AND TREATMENT

☐ Physical therapy ☐ Home exercise ☐ Chiropractic care ☐ Acupuncture ☐ Massage ☐ Bracing ☐ Heat/Ice

Dates/duration and response: _____

☐ X-ray ☐ MRI ☐ CT ☐ EMG/NCS ☐ Ultrasound ☐ Other

Body part, facility, and approximate date: _____

Previous pain physician(s): _____

☐ Epidural injection ☐ Facet/medial branch block ☐ Radiofrequency ablation ☐ Nerve block

☐ Joint injection ☐ Trigger point injection ☐ Spinal cord stimulator ☐ Other procedure

Procedure(s), date(s), and amount/duration of relief:

Prior spine, orthopedic, or pain-related surgery:



COMPREHENSIVE MEDICAL AND PAIN INTAKE HISTORY — CONTINUED

Patient Name: _____

Date of Birth: _____

CURRENT MEDICATIONS

Include prescription medications, over-the-counter medications, vitamins, and supplements.

Medication	Dose	How Often	Reason

ALLERGIES

☐ No known drug allergies ☐ Medication allergy ☐ Latex ☐ Adhesive ☐ Contrast dye ☐ Food ☐ Other

Allergen	Reaction

MEDICAL HISTORY — CHECK ALL THAT APPLY

☐ High blood pressure ☐ Heart disease ☐ Heart attack ☐ Stroke/TIA ☐ High cholesterol ☐ Diabetes
☐ Asthma ☐ COPD/emphysema ☐ Sleep apnea ☐ Kidney disease ☐ Liver disease ☐ Thyroid disease
☐ Cancer ☐ Seizures ☐ Neuropathy ☐ Arthritis ☐ Osteoporosis ☐ Fibromyalgia
☐ Depression ☐ Anxiety ☐ Blood clot/DVT/PE ☐ Bleeding disorder ☐ Anemia ☐ Autoimmune disease
☐ Stomach ulcer/GERD ☐ Glaucoma ☐ Infection ☐ HIV ☐ Hepatitis ☐ Other: _____ ☐ None

Please explain checked conditions: _____

SURGICAL AND HOSPITALIZATION HISTORY

Surgery/Hospitalization	Approximate Date	Reason

FAMILY HISTORY

☐ Heart disease ☐ High blood pressure ☐ Diabetes ☐ Stroke ☐ Cancer ☐ Blood clots ☐ Chronic pain ☐ Other

Relationship and details: _____

SOCIAL HISTORY

☐ Never smoked ☐ Former smoker ☐ Current smoker ☐ Vape/e-cigarette

Amount and years: _____

☐ No alcohol ☐ Occasional alcohol ☐ Regular alcohol use

Type/frequency: _____

☐ No recreational drug use ☐ Current use ☐ Past use

Type/frequency: _____

Occupation: _____

☐ Working ☐ Not working ☐ Retired ☐ Disabled

Living situation/support: _____

REVIEW OF SYSTEMS

Check any symptoms you are currently experiencing.

CONSTITUTIONAL	☐ Fever ☐ Chills ☐ Fatigue ☐ Weight loss/gain ☐ Night sweats
EYES	☐ Vision change ☐ Blurred vision ☐ Double vision ☐ Eye pain
ENT	☐ Hearing change ☐ Dizziness ☐ Difficulty swallowing ☐ Hoarseness
CARDIOVASCULAR	☐ Chest pain ☐ Palpitations ☐ Fainting ☐ Leg swelling
RESPIRATORY	☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Sleep apnea
GASTROINTESTINAL	☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Constipation ☐ Diarrhea
GENITOURINARY	☐ Painful urination ☐ Incontinence ☐ Urgency ☐ Retention
MUSCULOSKELETAL	☐ Neck pain ☐ Back pain ☐ Joint pain ☐ Muscle pain ☐ Swelling
SKIN	☐ Rash ☐ Wound ☐ Color change ☐ Itching
NEUROLOGIC	☐ Headache ☐ Dizziness ☐ Weakness ☐ Numbness ☐ Tingling ☐ Falls
PSYCHIATRIC	☐ Depression ☐ Anxiety ☐ Sleep difficulty ☐ Mood change
ENDOCRINE	☐ Heat/cold intolerance ☐ Excess thirst ☐ Excess urination
HEMATOLOGIC	☐ Easy bruising ☐ Easy bleeding ☐ Anemia ☐ Enlarged lymph nodes
ALLERGIC/IMMUNE	☐ Seasonal allergies ☐ Recurrent infections ☐ Immune disorder



LASER SPINE CENTER OF CHICAGO
COMPREHENSIVE MEDICAL AND PAIN INTAKE HISTORY — CONTINUED

Patient Name: _____

Date of Birth: _____

PAIN DIAGRAM

Mark the location of your pain and use arrows to show radiation. Label numbness (N), tingling (T), or weakness (W).

PATIENT CERTIFICATION I certify that the information provided in this medical history is true and complete to the best of my knowledge. I understand that incomplete or inaccurate information may affect my care.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



**LASER SPINE CENTER OF CHICAGO
HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

Patient Name: _____

Date of Birth: _____

ACKNOWLEDGMENT

I acknowledge that I have been offered or provided access to Laser Spine Center of Chicago's Notice of Privacy Practices. The Notice explains how my protected health information may be used and disclosed and describes my rights regarding that information.

PATIENT RIGHTS

I understand that I may request a paper copy of the Notice at any time and that the practice may revise its Notice as permitted by law.

OPTIONAL REASON IF NOT SIGNED

If the patient or representative declines or is unable to sign, staff may document the reason below.

Reason: _____

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



LASER SPINE CENTER OF CHICAGO

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

AUTHORIZATION

I authorize Laser Spine Center of Chicago to obtain from and disclose to my physicians, hospitals, imaging centers, laboratories, pharmacies, therapists, insurance carriers, attorneys when authorized, and other healthcare entities the medical information reasonably necessary for treatment, payment, healthcare operations, care coordination, utilization review, and insurance authorization.

INFORMATION COVERED

This authorization may include office notes, consultation reports, medication history, laboratory results, imaging reports and images, therapy records, operative reports, procedure records, billing information, and other records relevant to my care.

LIMITATIONS AND REVOCATION

I understand that I may revoke this authorization in writing, except to the extent action has already been taken in reliance on it. Information disclosed may be subject to redisclosure as permitted by applicable law. This authorization does not permit release for unrelated marketing purposes.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



LASER SPINE CENTER OF CHICAGO

INSURANCE ASSIGNMENT OF BENEFITS AND AUTHORIZATION

Patient Name: _____

Date of Birth: _____

ASSIGNMENT OF BENEFITS

I assign directly to Laser Spine Center of Chicago all insurance and healthcare benefits payable for services provided to me. I authorize payment directly to the practice and authorize the practice to submit claims and related documentation on my behalf.

RELEASE OF INFORMATION

I authorize the release of medical, billing, and other information reasonably required to verify coverage, obtain authorization, process claims, appeal denials, coordinate benefits, and obtain payment.

PATIENT RESPONSIBILITY

I understand that verification of benefits or prior authorization is not a guarantee of payment. I am responsible for copays, deductibles, coinsurance, noncovered services, denied services when patient responsibility applies, and other amounts permitted by my insurance contract and applicable law.

ACCURACY OF INFORMATION

I agree to provide current and accurate insurance information and to promptly notify the practice of any change in coverage.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



LASER SPINE CENTER OF CHICAGO

FINANCIAL POLICY AND PATIENT RESPONSIBILITY AGREEMENT

Patient Name: _____

Date of Birth: _____

INSURANCE AND PAYMENT

Insurance is billed as a courtesy. I understand that my insurance policy is a contract between me and my insurer. Copays, deductibles, coinsurance, and known patient-responsibility amounts are due at the time of service unless other arrangements have been approved.

COVERAGE AND AUTHORIZATIONS

Benefit verification and prior authorization do not guarantee payment. I may be financially responsible for services that are excluded, noncovered, denied, or applied to my deductible or coinsurance, to the extent permitted by law and my insurance agreement.

OUTSTANDING BALANCES

I agree to make reasonable payment arrangements for outstanding balances. Significant past-due balances may affect scheduling of nonemergency services, consistent with applicable law, payer requirements, and practice policy.

CANCELLATIONS AND NO-SHOWS

I agree to provide at least 24 hours' notice when I cannot keep an appointment. Repeated late cancellations or missed appointments may result in a fee when permitted, limits on future scheduling, or discharge from the practice after appropriate notice.

RETURNED PAYMENTS AND COLLECTIONS

I am responsible for any lawful returned-payment fee and reasonable collection costs permitted by law. I agree to contact the billing office promptly if I believe a statement is incorrect or if I need to discuss payment arrangements.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



LASER SPINE CENTER OF CHICAGO
MEDICATION AND CONTROLLED-SUBSTANCE AGREEMENT

Patient Name: _____

Date of Birth: _____

APPLICABILITY

This agreement applies only if the practice prescribes controlled substances or requires it as part of medication management.

SAFE USE

I will take medications only as prescribed and will not change the dose, frequency, or manner of use without approval. I will not share, sell, trade, or obtain controlled medication through deceptive means. I will store medication securely and dispose of unused medication safely.

PRESCRIBERS AND PHARMACIES

I will inform the practice of all controlled medications prescribed by other clinicians. When directed, I will use one pharmacy and one prescribing practice for chronic controlled medication, except in an emergency or when coordinated with the practice

.

MONITORING

I understand that safe prescribing may include review of prescription-monitoring databases, medication counts, toxicology or urine drug testing, review of records, and periodic reassessment of benefits, risks, function, and adherence.

REFILLS AND LOST MEDICATION

I will request refills during regular business hours and before I run out. Early refills are not guaranteed. Lost, stolen, damaged, or destroyed medication may not be replaced. A police report may be requested for reported theft.

SAFETY AND DISCONTINUATION

I will not drive or perform hazardous activities if impaired. I will discuss alcohol, sedatives, sleep medications, or other substances that may increase risk. Medication may be tapered, changed, or discontinued when risks outweigh benefits, there is unsafe use, monitoring is inconsistent with the treatment plan, or the agreement is not followed.

ACKNOWLEDGMENT

I understand that signing this agreement does not guarantee that controlled medication will be prescribed.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



LASER SPINE CENTER OF CHICAGO
CONSENT FOR URINE DRUG AND TOXICOLOGY SCREENING

Patient Name: _____

Date of Birth: _____

CONSENT

When clinically indicated as part of medication management, I consent to urine, oral-fluid, blood, or other appropriate toxicology testing. Testing may evaluate prescribed medications, nonprescribed medications, controlled substances, alcohol-related markers, or other substances relevant to safe care.

PURPOSE

I understand that testing is used to support patient safety, assess medication adherence, identify potentially dangerous combinations, and guide treatment decisions. Results will be interpreted in clinical context, and confirmatory testing may be ordered when appropriate.

SPECIMEN INTEGRITY

I agree to provide a valid specimen and understand that refusal, substitution, adulteration, or unexplained inconsistent results may require further evaluation and may affect the treatment plan.

FINANCIAL RESPONSIBILITY

I understand that specimens may be tested by an outside laboratory and that coverage varies. I may be responsible for applicable deductibles, coinsurance, or noncovered charges, subject to insurance rules and applicable law.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



Laser Spine Center of Chicago

LASER SPINE CENTER OF CHICAGO PATIENT RIGHTS AND RESPONSIBILITIES

Patient Name: _____

Date of Birth: _____

PATIENT RIGHTS

You have the right to respectful, nondiscriminatory care; privacy and confidentiality; understandable information about your condition and proposed care; participation in treatment decisions; discussion of reasonable alternatives; access to your records as permitted by law; information about practice policies and charges; and the ability to voice concerns without retaliation.

PATIENT RESPONSIBILITIES

You are responsible for providing complete and accurate health, medication, allergy, insurance, and contact information; asking questions when information is unclear; participating in the agreed treatment plan; treating staff and other patients respectfully; keeping appointments or providing timely notice; following medication and safety instructions; promptly reporting significant changes; and meeting financial obligations permitted by your insurance agreement and applicable law.

CONCERNS

Questions or concerns may be directed to the practice administrator. You may also contact your health plan or an appropriate regulatory agency when applicable.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____



LASER SPINE CENTER OF CHICAGO

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

AUTHORIZATION

I authorize Laser Spine Center of Chicago to discuss or disclose the categories of information selected below with the person(s) I identify. This authorization is voluntary and may be revoked by me in writing, except to the extent the practice has already relied on it.

AUTHORIZED PERSON 1

Name: _____	Relationship: _____
Phone: _____	Email (optional): _____

AUTHORIZED PERSON 2

Name: _____	Relationship: _____
Phone: _____	Email (optional): _____

INFORMATION THAT MAY BE DISCUSSED

- ☐ Appointments/scheduling ☐ General medical information ☐ Test/imaging results ☐ Medications
☐ Treatment plan ☐ Billing/insurance ☐ All medical and billing information ☐ Other: _____

RESTRICTIONS

Information that may NOT be discussed:

EXPIRATION

- ☐ This authorization remains effective until I revoke it in writing. ☐ Expires on: _____

I understand that information disclosed to an authorized person may no longer be protected from redisclosure. This authorization does not require the practice to disclose information when disclosure would be inappropriate or prohibited by law.

Patient/Legal Representative Signature: _____	Date: _____
Printed Name: _____	Relationship (if applicable): _____