



AMERICAN HIP INSTITUTE & ORTHOPEDIC SPECIALISTS

Patient Intake Form

Patient information		Referring MD Information	
Name		Name	
Address		Address	
City/ State/ Zip		City/State/Zip	
DOB			
Home Phone		Telephone	
Cell Phone		Fax	
Email			
Insurance information			
Carrier			
ID#			
Group #			
Name of Insured			
DOB of Insured			

999 E. Touhy Ave Suite 450
Des Plaines, IL 60018

P: (833) USA-HIPS 872-4477
F: (630) 323-5625
www.AmericanHipInstitute.com

9615 Keilman st.
St. John, IN 46373



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Out of Town Review Questions

Where is your pain located?

How long has your pain been present? Did you have an injury? If yes, please describe.

Have you been given a diagnosis? Who gave the diagnosis? What was the diagnosis?

Do you or have you taken NSAIDS or any other medication for relief? Please list medications taken for your current condition.

Have you had physical therapy specific to your condition?
If yes, how many visits? Did you have relief?

Have you had any injections for your current condition?
If yes, please describe what type. Did you have relief? For how long?

Have you had previous surgery for your current condition?
If yes, please describe what type. Did you have relief? For how long?

Have you had any imaging studies for your current condition? Xray, MRI, CT, etc.
If yes, please describe what type, dates performed.

How did you *first* hear about the American Hip Institute?
