



Patient Information

Ventura Orthopedics

Account # :

Last Name:		First Name:		MI:
Address:		City:		Zip:
Home Phone :	<input type="checkbox"/> OK to leave msg	Cell Phone:	<input type="checkbox"/> OK to leave msg	
Work Phone:	<input type="checkbox"/> OK to leave msg	Email :		
Family Physician (PCP):		Referring Provider:		
DOB:	Marital Status:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security:	
Employer:		Employer Address:		
Emergency Contact:		Relationship:	Contact Phone:	

IF PATIENT IS A MINOR Student Status: Full Time Part Time

Father's Name:		Mother's Name:	
Work Phone:		Work Phone:	
Employer:		Employer:	
Email:		Email:	

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Subscriber:		Subscriber:	
Birth date:		Birth date:	
Subscriber Relationship to Patient:		Subscriber Relationship to Patient:	
Subscriber Employer:		Subscriber Employer:	
ID #:	Grp #:	ID #:	Grp #:

INJURY INFORMATION

Date of Onset:	Area of Pain:
Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> OTHER _____	
How did Injury Occur:	

Race: <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> other _____ <input type="checkbox"/> Refuse to Report
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> other _____ <input type="checkbox"/> Refuse to Report
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> other _____

Each Patient (Or Responsible Party) is Financially Responsible for Services rendered. While we are please to assist in the Preparation of Insurance Forms, the obligation for payment of our fees remains that of the patient. I hereby authorize payment to Ventura Orthopedics for Medical Services rendered. I authorize the release of any information required in the course of my examination or treatment.

Responsible Party Name (Please Print) _____

Date _____

Signature of Responsible Party _____

Ventura Orthopedics

Instructions: This is a scanned document, Please fill in the circle O Do not use an X, check mark, or line

PATIENT INFORMATION

Patient Name:		Date:
DOB:	Height:	Weight
Referring Physician:		Primary Care Physician:

I. Did another doctor send you to this office for evaluation? Yes No

Would you like your medical report sent to your other provider? Yes No

If so, please list provider information: _____

II. Which side is affected? Right Left Bilateral

Problem involves the: Shoulder Elbow Forearm Wrist Hand

Finger Neck Hip Thigh Knee

Leg Ankle Foot Toe Back

III. Was there an injury which you believe directly resulted in your symptoms? Yes No (If no, skip to IV.)

If so, what is the date of injury: _____

Is the injury work related? Yes No

Is this the result of a motor vehicle accident? Yes No

IV: Please give an approximate time (date, month, or year) when the symptoms began: _____

V. Describe the injury and/or development of your problem: _____

VI. Have you sought medical treatment for this problem prior to this visit? Yes No

If so, where: Emergency Room Urgent Care Physician's Office Other

Name of care provider and/or facility who treated you: _____

What kind of treatment was given? Brace/Splint Crutches Cast Therapy Chiropractic

What medication was given? Narcotic (Vicodin, Codeine, etc) Anti-inflammatory (Advil, Motrin, etc)

Muscle Relaxer (Flexeril, Soma, etc) Corticosteroid (Medrol Dosepak) Injection

Other: _____

VII. Have you EVER had any of the following studies:	Body Part	Month/Year
X-rays <input type="radio"/> Yes <input type="radio"/> No	_____	_____
CT Scan <input type="radio"/> Yes <input type="radio"/> No	_____	_____
MRI <input type="radio"/> Yes <input type="radio"/> No	_____	_____
Nerve Test <input type="radio"/> Yes <input type="radio"/> No	_____	_____
Arthrogram <input type="radio"/> Yes <input type="radio"/> No	_____	_____
Myleogram <input type="radio"/> Yes <input type="radio"/> No	_____	_____
Discogram <input type="radio"/> Yes <input type="radio"/> No	_____	_____

Have you had surgery on this body part? Yes No

Have you had symptoms or an injury to this area before? Yes No

If so, please describe: _____

Review of Systems: Are you experiencing any of these issues now?

Are you pregnant?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A				
General	Fever	<input type="radio"/> Yes	<input type="radio"/> No		Night Sweats/Chills	<input type="radio"/> Yes	<input type="radio"/> No	
	Night Pain	<input type="radio"/> Yes	<input type="radio"/> No		Weight Loss	<input type="radio"/> Yes	<input type="radio"/> No	
Eyes	Cataracts	<input type="radio"/> Yes	<input type="radio"/> No		Blindness	<input type="radio"/> Yes	<input type="radio"/> No	
	Double Vision	<input type="radio"/> Yes	<input type="radio"/> No					
HEENT	Cough	<input type="radio"/> Yes	<input type="radio"/> No		Sinus Problems	<input type="radio"/> Yes	<input type="radio"/> No	
	Sore Throat	<input type="radio"/> Yes	<input type="radio"/> No		Hearing Loss	<input type="radio"/> Yes	<input type="radio"/> No	
	Dentures	<input type="radio"/> Yes	<input type="radio"/> No		Loose Tooth	<input type="radio"/> Yes	<input type="radio"/> No	
Heart	Chest Pain	<input type="radio"/> Yes	<input type="radio"/> No		Irregular Heart Beats	<input type="radio"/> Yes	<input type="radio"/> No	
	High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No					
Lungs	Wheezing	<input type="radio"/> Yes	<input type="radio"/> No		Shortness of Breath	<input type="radio"/> Yes	<input type="radio"/> No	
	Pain with Breathing	<input type="radio"/> Yes	<input type="radio"/> No		Sputum Production	<input type="radio"/> Yes	<input type="radio"/> No	
Abdominal	Heartburn	<input type="radio"/> Yes	<input type="radio"/> No		Difficult Swallowing	<input type="radio"/> Yes	<input type="radio"/> No	
	Nausea & Vomiting	<input type="radio"/> Yes	<input type="radio"/> No		Blood in Stool	<input type="radio"/> Yes	<input type="radio"/> No	
	Liver Disease	<input type="radio"/> Yes	<input type="radio"/> No					
Urinary	Blood in Urine	<input type="radio"/> Yes	<input type="radio"/> No		Pain with Urination	<input type="radio"/> Yes	<input type="radio"/> No	
	Incontinence	<input type="radio"/> Yes	<input type="radio"/> No		Kidney Stones	<input type="radio"/> Yes	<input type="radio"/> No	
Musculoskeletal								
	Joint Swelling	<input type="radio"/> Yes	<input type="radio"/> No		Joint Redness	<input type="radio"/> Yes	<input type="radio"/> No	
	Muscle Cramps	<input type="radio"/> Yes	<input type="radio"/> No		Stiffness	<input type="radio"/> Yes	<input type="radio"/> No	
Skin & Breast	Rash	<input type="radio"/> Yes	<input type="radio"/> No		Changes in Moles	<input type="radio"/> Yes	<input type="radio"/> No	
	Lumps	<input type="radio"/> Yes	<input type="radio"/> No		Discharge	<input type="radio"/> Yes	<input type="radio"/> No	
Neurologic	Seizures	<input type="radio"/> Yes	<input type="radio"/> No		Loss of Consciousness	<input type="radio"/> Yes	<input type="radio"/> No	
	Tremor	<input type="radio"/> Yes	<input type="radio"/> No		Paralysis	<input type="radio"/> Yes	<input type="radio"/> No	
	Balance Problems	<input type="radio"/> Yes	<input type="radio"/> No		Headaches	<input type="radio"/> Yes	<input type="radio"/> No	
Psychiatric	Depression	<input type="radio"/> Yes	<input type="radio"/> No		Hyperactivity	<input type="radio"/> Yes	<input type="radio"/> No	
	Anxious	<input type="radio"/> Yes	<input type="radio"/> No		Crying Spells	<input type="radio"/> Yes	<input type="radio"/> No	
	Loss of Appetite	<input type="radio"/> Yes	<input type="radio"/> No		Social Withdrawal	<input type="radio"/> Yes	<input type="radio"/> No	
Metabolism	Weight Gain	<input type="radio"/> Yes	<input type="radio"/> No		High Blood Sugar	<input type="radio"/> Yes	<input type="radio"/> No	
	Clammy	<input type="radio"/> Yes	<input type="radio"/> No		Tired	<input type="radio"/> Yes	<input type="radio"/> No	
Blood	Anemia	<input type="radio"/> Yes	<input type="radio"/> No		Prolonged Bleeding	<input type="radio"/> Yes	<input type="radio"/> No	

Pediatrician: _____

Referring Physician: _____

Past Medical History

Please list any medical problems (asthma, diabetes, etc) or circle NONE

Past Surgical History

Please list any surgeries that the patient has had and the dates of these surgeries or circle NONE

Has the patient ever been hospitalized? Yes No

If YES, please explain _____

Birth and Developmental History

Was the patient a full-term baby (born at 9 months?) Yes No

If NO, at how many weeks or months of pregnancy was (s)he delivered? _____

Were there any complications during the pregnancy, delivery, or around the time of birth? Yes No

If YES, please explain _____

Delivery was by: (please circle) Normal vaginal delivery Cesarean section

How old was the patient when (s)he walked? _____ Talked? _____

Medications

Please list any medications (and dosages) the patient takes _____

Any allergies to medications? Yes No

If YES, please list medication and the reaction _____

Social History

Who does the patient live with? _____

List any siblings and their ages _____

Does the patient play any sports or participate in any activities? Yes No

If YES, please list _____

What grade is the patient in? _____ At which school? _____

Family History

Please list any medical problems in patient's mother, father, or siblings _____



Ventura Orthopedics

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's notice of Privacy Practice. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practice.

Signature

Date

Print Name

Telephone Number

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____