Patient Demographic

Account # :

Last Name	First Name	MI:
Address	City	State / Zip Code

Home Phone :	☐ OK to leave msg	Cell Phone:	☐ OK to leave msg
Work Phone:	☐ OK to leave msg	Email :	

Family Physician(Full Name & City of Practice):	Referring Provider(Full Name & City of Practice):

DOB:	Marital Status:	Sex: ☐ M ☐ F	Social Security:

Employer:	Employer Address:

Emergency Contact:	Relationship:	Phone:

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Subscriber/Policy Holder Name:		Subscriber/Policy Holder Name:	
Birth date:		Birth date:	
Relationship to Patient:		Relationship to Patient:	
Social Security #:		Social Security #:	
ID No:	Group No:	ID No:	Group No:

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:

INJURY INFORMATION

Date of Onset:	Area of Pain:
Injury: ☐ Yes ☐ No	If yes, ☐ AUTO ☐ WORK ☐ OTHER ____________________
How did Injury Occur:	

Race: ☐Hispanic ☐White ☐Asia ☐African American ☐Native Hawaiian ☐other ______________ ☐Refuse to Report

Ethnicity: ☐Hispanic ☐Non Hispanic ☐other ________________ ☐Refuse to Report

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐other ___________________

Each Patient (Or Responsible Party) is Financially Responsible for Services rendered. While we are pleased 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 ____________________________________

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

Mark the areas where you feel the above pain or sensation

FRONT — Right / Left — BACK — Left / Right

On the scale below place an X next to your pain level (10 = worst pain).

0 ______________ 5 ______________ 10

How much of your total pain is:

Neck or Back pain ________%

Arm or leg pain (including hip/buttocks) ________%

Total 100%

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

II. Problem involves my: O Neck O Back

Problem radiates to my: O Right O Left O Shoulder O Arm O Hand

O Fingers O Hip O Thigh O Leg O Foot O Toes

III. Was there an injury which resulted in your symptom: O Yes O No Date of injury: ___________

Is the injury caused by work? O Yes O No If yes, Type of work: ________________

IV. Please give an approximate time (date, month, or year) when your symptoms began:________________

Briefly describe the injury and/or development of your problem: ____________________________

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

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

Name of Physician and/or facility who treated you: ______________________________________

What kind of treatment was given to you? O Physical Therapy O Injections

What medication was given? O Narcotic (Vicodin/Codeine) O Anti-Inflammatory (Advil/Motrin)

O Muscle Relaxers (Flexeril/Soma) O Steroids (Medrol Dosepak/Prednisone)

VII. Have you had any studies of the **involved area** within the **past year**? O X-Rays

O MRI O CT Scan O Myelogram O Discogram

Have you had surgery on this body part? O Yes O No Briefly Describe__________________

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

Does the pain keep you up at night? O Yes O No

How far can you walk (in miles or blocks)? ______________________________________

MEDICAL HISTORY:

High Blood Pressure O Yes O No Diabetes O Yes O No Heart Disease O Yes O No

Cancer O Yes O No Other: __________________

SOCIAL HISTORY: Tobacco Use: Are you a? O Current Smoker O Former Smoker O Never Smoked

If a current smoker, how long have you smoked? O <1 year O 1-10 years O 10+ years

Number of packs per day: O < 1 pack O 1-2 packs O 3+ packs

Do you drink alcohol regularly? O Yes O No

Drinks per week: O < 4 drinks O 5-9 drinks O 10 +

Have you used or do you use other drugs? O None O Street Drugs O Steroids O Other: _________

Level of education completed: O Elementary O High School O College O Graduate

Marital Status: O Single O Married O Divorced O Widowed

Job/Occupation: ______________________

FAMILY HISTORY: Bubble all medical conditions below that pertain to your family members:

Back Problems	O Yes	O No	Neck Problems	O Yes	O No
Cancer	O Yes	O No	Heart Failure	O Yes	O No
Heart Attacks	O Yes	O No	Emphysema	O Yes	O No
Diabetes	O Yes	O No	Epilepsy	O Yes	O No
High Blood Pressure	O Yes	O No	Arthritis	O Yes	O No
Alcoholism	O Yes	O No	Stroke	O Yes	O No
Mental Illness	O Yes	O No	Other_____________________________________		

REVIEW OF SYSTEMS: Bubble all that pertain to you:

Are you Pregnant? O Yes O No O N/A **Allergies:** Allergic to medication O Yes O No

General:	Fever	O Yes	O No	Night Sweats/Chills	O Yes	O No
Eyes:	Cataracts	O Yes	O No	Double Vision	O Yes	O No
Head/Neck:	Sinusitis	O Yes	O No	Sore Throat	O Yes	O No
Heart:	Chest Pain	O Yes	O No	Irregular Heart Beat	O Yes	O No
	High Blood Pressure	O Yes	O No			
Lungs:	Shortness of Breath	O Yes	O No	Sputum Production	O Yes	O No
Abdominal:	Heartburn	O Yes	O No	Nausea and Vomiting	O Yes	O No
Urinary:	Incontinence	O Yes	O No			
Skeletal:	Joint Swelling	O Yes	O No	Joint Redness	O Yes	O No
	Muscle Cramps	O Yes	O No	Stiffness	O Yes	O No
Neurologic:	Seizures	O Yes	O No	Balance Problems	O Yes	O No
	Headaches	O Yes	O No			
Mental:	Depression	O Yes	O No	Anxious	O Yes	O No
	Fatigue	O Yes	O No	Difficulty Sleeping	O Yes	O No
Blood:	Prolonged Bleeding	O Yes	O No	Anemia	O Yes	O No

Medications (Please list name of medication and dosage)	
Hospitalization (Please list)	Surgeries(Please list surgery type and dates)
Medications you are allergic to (Please list)	

Patient Signature:________________________________ Date:____________________

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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 nótice 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: ______________________________