Neck & Spine Patient Demographic

☐ New Patient ☐ Return Patient ☐ Update | Account #: ____________________

Last Name ______________________ First Name ______________________ MI: ______

Address ______________________ City ____________ State ______ Zip ________

Home Phone ______________ ☐ OK to Leave Msg. Cell Phone ______________ ☐ OK to Leave Msg.

Work Phone ______________ ☐ OK to Leave Msg. Email ______________________

Do you prefer to receive reminder messages in the: ☐ Morning ☐ Afternoon ☐ Evening

Do you prefer: ☐ Voice Message ☐ Text Message ☐ ***If you would like to make special arrangements regarding how we should contact you please see a staff member.***

Family Physician ______________________ Referring Provider ______________________

DOB __________ Marital Status __________ Sex: ☐ M ☐ F Social Security # ______________

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 # ______________ Group # __________ ID # ______________ Group # __________

If Patient is a Minor

Student Status: ☐ Full Time ☐ Part Time

Father's Name ______________________ Mother's Name ______________________

DOB ______________________ DOB ______________________

Cell Phone ______________________ Cell Phone ______________________

Personal Demographic

Race: ☐ Hispanic ☐ White ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Other __________ ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other ______________ ☐ Refuse to Report

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐ Other ____________

Do you need an interpreter present during your examination? ☐ Yes ☐ No

How Did You Hear About Us?

☐ Physician ☐ Family/Friend ☐ VO Website ☐ Internet Search ☐ Advertisement ☐ Review Website ☐ Social Media

☐ Other ______________ Specifically, who or what was the source? ______________________

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)	Signature of Responsible Party	Date

OFFICE USE ONLY

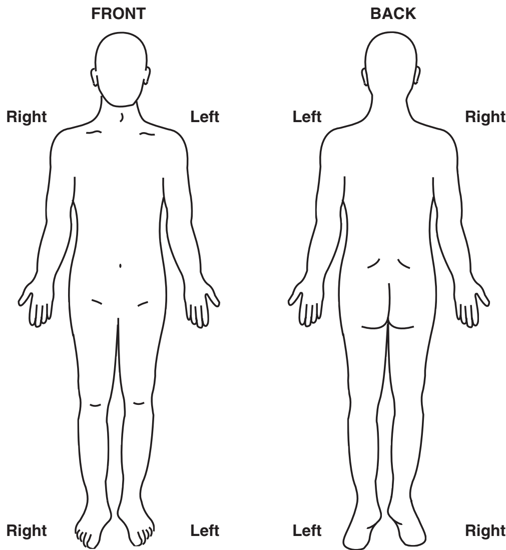
Vitals ______________________

____

Patient Name ____ Date __________

Date of Birth ______________________ Height __________ Weight __________

Referring Physician ____________________________ Primary Care Physician ______________________________



On the diagram at left, mark the area where you feel pain or sensation.

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? ☐ Yes ☐ No

If yes, who referred you: ____

II. Problem involves my: ☐ Neck ☐ Back

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

☐ Fingers ☐ Hip ☐ Thigh ☐ Leg ☐ Foot ☐ Toes ☐ Toes

III. Was there an injury which resulted in your symptoms? ☐ Yes ☐ No Date of injury: ______________

Is the injury work related? ☐ Yes ☐ No If yes, type of work: ______________________

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

V. 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 treatment was given? ☐ Physical Therapy ☐ Injections

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

☐ Muscle relaxers *(Flexeril, Soma, etc.)* ☐ Steroids *(Medrol Dosepak, etc.)*

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

☐ X-Rays ☐ CT/CAT Scan ☐ MRI ☐ Myelogram ☐ Discogram

Have you had surgery on this body part? ☐ Yes ☐ No

If yes, please describe:____

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

If yes, please describe:____

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

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

Medical History

☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Cancer

☐ Other: ______________________________

Social History

Tobacco Use: Are you a... ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

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

How many cigarette packs per day? ☐ <1 pack ☐ 1-2 packs ☐ 3+ packs

If you used cigarettes in the past, but no longer smoke, when did you quit smoking?______________________

Do you drink alcohol regularly? ☐ Yes ☐ No

How many drinks per week? ☐ <4 drinks ☐ 5-9 drinks ☐ 10+ drinks

Have you used or do you use other drugs? ☐ None ☐ Street Drugs ☐ Steroids ☐ Other ______________

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: ______________________

Family History

Mother	☐ Alive	☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Unknown
Father	☐ Alive	☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Unknown
Siblings	☐ Alive	☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Unknown

Pregnancy

If you are a Female between the age of 10-65, are you pregnant? ☐ Yes ☐ No

Allergies

Are you allergic to any medications? ☐ Yes ☐ No Please List:______________________

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

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

Medications *(Please list name of medication and dosage)*

____

____

____

Hospitalizations *(Please list all hospitalizations you have had)*

____

____

____

Surgeries *(Please list all surgeries type and year)*

____

____

____

Patient Signature____ Date ____________________

Physician Signature____ Date ____________________

Ventura Orthopedics

Acknowledgement of Receipt of Notice

Ventura Orthopedics Medical Group, Inc.
www.venturaortho.com
Administrator | 805-641-6415

Patient Name ____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

(please check one)

☐ Yes ☐ No I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

Signed: ______________________ Date: ______________________

Print Name: ______________________ Telephone: ______________________

If not signed by the patient, please indicate your relationship to the patient:

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

Online Survey

Your feedback matters!

Please help us improve the patient experience by filling out a short survey that will be sent via text message or email. Your contact information will not be used for any other reason, including junk or spam mail.

☐ Yes, I would love to help.
☐ No, I do not wish to participate.

For Office Use Only:

☐ Signed form received by: ____

Request for Special Privacy Protections

Ventura Orthopedics Medical Group, Inc.
www.venturaortho.com
Administrator | 805-641-6415

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to members of your family and other relatives or close personal friends or other person you identity who are involved in your care or payment for your care, or to notify or assist in notifying those individuals of your location, general condition or death. This medical practice does not have to agree to your request, but if we do, we will abide by our agreement until either of us terminates the agreement.

I hereby request special privacy protection for ______________________________ ____________________
Print Patient's Name Patient's Date of Birth

You **MAY** speak/disclose my Health Information to:

Name: ______________________________

Phone: ______________________________

Relationship: ☐ Spouse ☐ Child
☐ Other ____________________

Name: ______________________________

Phone: ______________________________

Relationship: ☐ Spouse ☐ Child
☐ Other ____________________

Name: ______________________________

Phone: ______________________________

Relationship: ☐ Spouse ☐ Child
☐ Other ____________________

You **MAY NOT** speak/disclose my Health Information to:

Name: ______________________________

Phone: ______________________________

Relationship: ☐ Spouse ☐ Child
☐ Other ____________________

Name: ______________________________

Phone: ______________________________

Relationship: ☐ Spouse ☐ Child
☐ Other ____________________

Name: ______________________________

Phone: ______________________________

Relationship: ☐ Spouse ☐ Child
☐ Other ____________________

This is a complete list of all restrictions requested. All previous restriction requests are obsolete.

Signature: ______________________________ Date: ____________________

Print Name: ______________________________ Phone: ____________________

If not signed by the patient (or plan member), please indicate your relationship:

☐ Parent or guardian of minor patient ☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient ☐ Other (specify) ____________________

NOTE: By law, this restriction will not apply with respect to information necessary to provide emergency treatment, for uses or disclosures required by law, or for certain public health activities, judicial and administrative proceedings, law enforcement purposes, coroner investigations, organ or tissue donations, research activities, specialized government functions or workers' compensation activities.