

LA VETA ORTHOPAEDIC ASSOCIATES REGISTRATION FORM

The information on this form is kept confidential and will be part of your medical record.

TODAY'S DATE: _____ **YOUR PRIMARY CARE PHYSICIAN:** _____

PATIENT INFORMATION (Please fill out completely. This information is used to assist us in processing your claim.)

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms/Miss <input type="checkbox"/> Dr.	Marital Status	
						<input type="checkbox"/> Sgl	<input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
Street Address		City	State	ZIP Code	Birth Date	Age	
Sex	Social Security	Home Phone No. (can we leave messages on the answering machine regarding test results) <input type="checkbox"/> Yes <input type="checkbox"/> No		Cell Phone	Employer Phone No.		
<input type="checkbox"/> M <input type="checkbox"/> F		()		()	()		
Occupation		Employer	School or College attending				

Who REFERRED you: Dr. _____ Insurance Co. St Joseph Hosp Referral Svc.
 Family or Friend: who? Hospital ER Web/Internet site Yellow Pages Other: _____

Other FAMILY MEMBERS Seen in our Office:

Is the problem you are here for part of a Third Party Case (car accident)? No Yes Third Party: In the case of a litigated personal injury or any car accident injury your medical insurance cannot be billed and your charges today will have to be paid in full. Ask for the Third Party Policy form.

Where you injured on the job (Work Comp)? Yes No What was the date of your injury? (used for insurance billing) _____ or No Specific Injury Date

What body part(s) are you being seen for today? _____

HEALTH INSURANCE (PLEASE GIVE YOUR INS. CARD AND LICENSE TO THE RECEPTIONIST TO COPY)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No.
			()
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation	Employer	Employer Address	Employer Phone No.
			()

Please indicate your primary insurance:

Subscriber's Name	Subscriber's Social Security #	Birth Date	Group #	Policy #	Co-Pay \$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if applicable)		Subscriber's Name	Group #	Policy #	
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IMPORTANT: IN CASE OF EMERGENCY WHO CAN WE CONTACT FOR YOU (Please list 2 contacts)

Name of Friend or Relative	Relationship to Patient	Home Phone No.	Work/Cell Phone No.	Is it OK for us to discuss your medical information with them?
		()	()	<input type="checkbox"/> Yes <input type="checkbox"/> No
		()	()	<input type="checkbox"/> Yes <input type="checkbox"/> No

FINANCIAL AGREEMENT/ASSIGNMENT AND RELEASE

I hereby authorize and consent to the examination and treatment as deemed necessary by my physician at "La Veta Orthopaedic Associates". I have read the Financial Agreement on the other side of this form and I agree to be bound by its terms. I understand and agree that I am ultimately responsible for the balance on my account for any professional services or equipment rendered. I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party, insurance company, Third Party payer, or because of pending legal claims. I certify that the above information is true to the best of my knowledge.

I hereby authorize my insurance company, including Medicare, Private Insurance or other health plans to pay directly to my physician at "La Veta Orthopaedic Associates" all benefits I am entitled to accruing under my policy. I authorize my physician or insurance company to release any information required to process my claim and secure payment.

X _____
 PATIENT OR GUARDIAN SIGNATURE DATE

(TURN OVER FOR OUR FINANCIAL POLICY)

La Veta Orthopaedic Associates
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ORTHOPAEDIC SURGERY WORK COMP/MED LEGAL INITIAL EVALUATION

Please answer these questions regarding your injury. Please be specific and complete all questions. If at anytime you need more space, use the back of these sheets. This form will be part of your permanent medical record.

DATE THIS FORM FILLED OUT: _____ 200__

NAME: Last _____ M.I. _____ First _____

HOME ADDRESS: _____ CITY _____ ZIP _____

TELEPHONES: HOME () _____ WORK () _____

CELLULAR () _____

DATE OF BIRTH: _____ AGE: _____ S.S.N. _____ - _____ - _____

GENDER (CIRCLE): MALE FEMALE

WHAT HAND DO YOU WRITE WITH? (CIRCLE): RIGHT LEFT

OCCUPATION OR JOB TITLE: _____

HEIGHT _____ WEIGHT _____

FAMILY DOCTOR OR INTERNIST _____

HISTORY OF PRESENT ILLNESS (Please answer all questions)

Did your Injury occur at work? Yes/No Was it due to a SINGLE injury or due to a GRADUAL problem?

Date of injury _____ Date first reported _____ To whom? _____

What part (s) of the body were injured (be specific)? 1) _____ 2) _____

3) _____ 4) _____ 5) _____

Who was your employer at the time? _____

What was your occupation or Job title at that time? _____

How did the injury, incident or accident happen? _____

Did you finish your shift? YES/NO When did you report it? _____

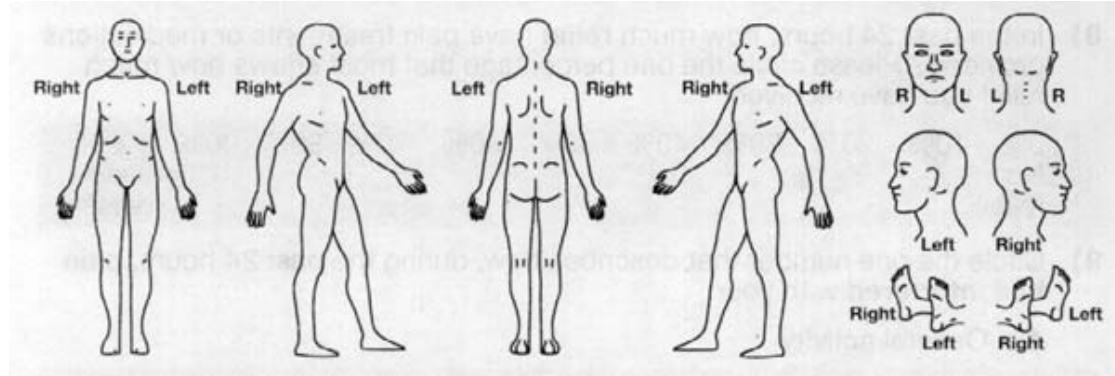
Have you RE-INJURED yourself since the first injury? YES/NO

Explain _____

Have you ever seen another doctor, chiropractor or other medical provider for treatment of these injured body parts? Yes or No _____

PRESENT COMPLAINTS (Please answer all questions)

Mark on the diagram the body parts that are painful with an X



Grade the SEVERITY of your pain. Use the scale from 1(very mild) through 10(excruciating):

What is your pain now: grade _____ WORSE pain gets: grade _____ BEST pain gets: grade _____

What makes it WORSE: _____

What makes it BETTER: _____

Describe the pain: _____ Does it hurt at rest? YES/NO

Pain Frequency: Constant or Intermittent What Percentage (%) of the day do you have pain? _____

What other symptoms do you experience other than pain: _____

Grinding or clicking? YES/NO Locking? YES/NO Giving-way? YES/NO Weakness ? YES/NO

Are your symptoms different today then they were at the initial onset? _____

What are you no longer able to do at WORK because of this injury? _____

What are you not able to do at HOME (sports, daily activities)? _____

TREATMENT TO DATE OF THIS INJURY

Name of the FIRST doctor or clinic seen if known? _____ Date seen: _____

Name of clinic or hospital _____ Who referred you there? Work? or Other: _____

What TESTS were initially done? (mark with "x") X-rays _____ CT Scan _____ MRI _____

Nerve Study (EMG/NCS) _____ Blood tests _____ Bone Scan _____ Other Studies _____

What were you initially told was wrong? _____

What treatment was initially suggested? Taken off work: YES/NO Given modified duty: YES/NO

Brace/Splint: YES/NO Steroid Injection _____ Cast _____

Medications given _____

Physical Therapy YES/NO How Many weeks _____ Where? _____

Where you hospitalized (where?) _____ Dates in hospital _____

Did you have Surgery (What type?) _____

Did you have follow-up visits with this same doctor or clinic? _____

What else was done for the injury so far? _____

List below OTHER doctors or medical professionals that you have seen for this injury.

1. Name and specialty _____ Date seen _____
 What did they do for you? _____

If you need more space to list doctors and treatments use the other side of this page to continue

WORK STATUS SINCE THIS INJURY (Please answer all questions)

When did you return to work? _____ Lost # of days _____ Date last worked: _____

Same employer? YES/NO Same position? YES/NO PART or FULL Time

Work Restrictions? YES/NO Specify: _____

Do you have a new employer since injured? Yes/No, Name _____

What specific duties can you not carry out because of your injury? _____

Have you been working a second job? _____ explain _____

YOUR PAST MEDICAL HISTORY

Do you have? (circle): Diabetes (insulin or no insulin) Heart Disease Angina Hepatitis HIV Bleeding problems Lung disease Cancer TB High blood Pressure Rheumatoid Arthritis Lupus Kidney disease Depression Bipolar disorder Peptic ulcer disease Gastritis Prostate dz Osteoporosis List others:

YOUR Medical Condition

YOUR Medical Condition

LIST YOUR OTHER PAST INJURIES OR ACCIDENTS

Injured body part	Date	Work related	Treatment	Status
		Yes or No		
		Yes or No		
		Yes or No		
		Yes or No		
		Yes or No		

PAST SURGERIES

Surgery	Date

MEDICATIONS

List Your Medications	

DO YOU HAVE ALLERGIES TO MEDICINE? YES/NO, To what? _____

SOCIAL HISTORY AND HOBBIES

Do you smoke now? Yes/ No Did you Quit?(when)_____ # cigs per day? _____ How many years? _____

Do you drink alcohol? Yes/ No How much and type? Daily_____ Weekly_____ Monthly_____

Are you under treatment or have been under treatment for: Drug addiction YES/NO Alcohol addiction YES/NO

Marital Status (circle): Married Single Separated Divorced Widowed # of Children_____

Hobbies/Interests (circle): Gardening Fishing Playing Instrument Golf Bowling Skiing Hunting Tennis
Cycling Hiking Reading Handiwork Mechanics Flying Time with family Other:_____

SYSTEM REVIEW

Are you experiencing or have ever had any of the following (circle): Shortness of Breath, dizziness, chest pain, passing out, multiple joint pain, urinating problems, stomach pain, infections, current fevers, menstrual problems, psychiatric problems, liver disease, HIV, Hepatitis B or C, previous heart disease or attacks, strokes, taken blood thinners

OCCUPATIONAL HISTORY

Employer at the time of Injury _____ Job title: _____

Is this your current employer? _____

How long had you been working there when you became injured? _____ years _____ months _____ days

Describe usual duties: _____

Do you have to lift? Yes/ No Explain _____

Do you have to reach overhead? Yes/ No Explain _____

Do you use a keyboard or mouse? Yes/ No Hours/day _____

Do you have to kneel, squat, bend down Yes/ No Explain _____

Do you currently have second job part or full time? Yes No Explain _____

OTHER EMPLOYERS

In chronological (most recent to oldest) order:

Previous employer _____ Occupation _____

From _____ To _____

Previous employer _____ Occupation _____

From _____ To _____

SIGNATURES

The information I provided above is accurate to the best of my recollection

Patient's Signature (or parent if patient is a minor) _____ Date _____

Interpreter Signature (If applicable) _____ Date _____