



Pediatric 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

Patient Name _____ Date _____

Vitals _____

Date of Birth _____ 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 yes, 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 yes, 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 treatment was given? Brace/Splint Crutches Cast Therapy Chiropractic
 What medication was given? Narcotic (*Vicodin, Codeine, etc.*) Anti-inflammatory (*Advil, Motrin, etc.*)
 Muscle Relaxers (*Flexeril, Soma, etc.*) Corticosteroids (*Medrol Dosepak, etc.*) Injection
 Other _____

- VII. Have you **EVER** had any of the following studies?
- | | Yes | No | Body Part | Month/Year |
|-------------|--------------------------|--------------------------|-----------|------------|
| X-rays | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| CT/CAT Scan | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| MRI | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Nerve Test | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Arthrogram | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Myelogram | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Discogram | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
- Have you had surgery on this body part? Yes No
 Have you had symptoms or an injury to this area before? Yes No
 If yes, please describe: _____

Pregnancy

If you are a Female between the age of 10-17, are you pregnant?

Yes No

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

General	Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Sweats/Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Night Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyes	Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
HEENT	Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Dentures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loose Tooth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart	Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular Heart Beats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Lungs	Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pain with Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sputum Production	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal	Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficult Swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nausea & Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Urinary	Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Musculoskeletal	Joint Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Stiffness	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Skin & Breast	Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Changes in Moles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurologic	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of Consciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Balance Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hyperactivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Sleeping	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Metabolism	Weight Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Sugar	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prolonged Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Pediatrician _____

Referring Physician _____

Past Medical History

Please list any medical problems (asthma, diabetes, etc.) or check None

Past Surgical History

Please list any surgeries that the patient has had and the dates of these surgeries, or check None

Hospitalizations

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 Normal vaginal delivery Cesarean section

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

Speech development was Normal Delayed

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

Allergies

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

Are you allergic to food or environmental substances? Yes No Please List: _____

Social History

With whom does the patient live? _____

List any siblings and their ages _____

Does the patient play sports or participate in activities? Yes No If yes, please list: _____

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

Family History

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

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 identify 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.