Ventura Orthopedics

Workers Compensation Demographic

Account #: _____ | Physician: _____

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 _____ Address _____

Referring Provider _____ Address _____

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

Employer _____ Address _____

Emergency Contact _____ Relationship _____ Phone _____

Work Comp Information

Insurance _____

Address _____

Phone _____ Fax _____

Adjuster _____ Claim # _____

Employer:

Address _____

Phone _____

Contact Person _____

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

Patient Name _____ Date _____

Date of Birth _____ Height _____ Weight _____

OFFICE USE ONLY

Vitals _____

_____

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

If yes, who referred you: _____

II. Problem involves the: ☐ Right ☐ Left ☐ Bilateral

☐ 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.)***

Date of injury: _____

Is the injury work related? ☐ Yes Is this the result of a motor vehicle accident? ☐ Yes

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 medication *(Advil, Motrin, etc.)*

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

VII. **For the problem you are being seen for today,** have you had any of the following:

☐ X-rays ☐ CT/CAT Scan ☐ MRI ☐ Nerve Test ☐ Arthrogram ☐ Myelogram ☐ Discogram

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: _____

VIII. Are you experiencing pain at the present time? ☐ Yes ☐ No

Pain is described as: ☐ Improved ☐ Worse ☐ The Same ☐ Mild ☐ Moderate ☐ Severe ☐ Sharp

☐ Dull ☐ Burning ☐ Aching ☐ Constant ☐ Present only at times or with certain activities

Does the pain radiate? ☐ Yes ☐ No If yes, where on your body? _____

Is there: ☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ A Mass ☐ Deformity

What makes your problem worse? _____

What makes your problem better? _____

Medical History

☐ Osteoporosis ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Paralysis

☐ Arthritis ☐ Ulcers ☐ Poor Circulation ☐ Asthma ☐ 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

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

General	Fever	☐ Yes	☐ No	Night Sweats/Chills	☐ Yes	☐ No
	Night Pain	☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No
Eyes	Cataracts	☐ Yes	☐ No	Blindness	☐ Yes	☐ No
	Double Vision	☐ Yes	☐ No			
HEENT	Cough	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
	Sore Throat	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
	Dentures	☐ Yes	☐ No	Loose Tooth	☐ Yes	☐ No
Heart	Chest Pain	☐ Yes	☐ No	Irregular Heart Beats	☐ Yes	☐ No
	High Blood Pressure	☐ Yes	☐ No			
Lungs	Wheezing	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
	Pain with Breathing	☐ Yes	☐ No	Sputum Production	☐ Yes	☐ No
Abdominal	Heartburn	☐ Yes	☐ No	Difficult Swallowing	☐ Yes	☐ No
	Nausea & Vomiting	☐ Yes	☐ No			
Urinary	Incontinence	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Musculoskeletal	Joint Swelling	☐ Yes	☐ No	Muscle Cramps	☐ Yes	☐ No
	Stiffness	☐ Yes	☐ No			
Skin & Breast	Rash	☐ Yes	☐ No	Changes in Moles	☐ Yes	☐ No

Review of Systems: Are you experiencing any of these issues now? *(continued)*

Neurologic	Seizures	☐ Yes	☐ No	Loss of Consciousness	☐ Yes	☐ No
	Balance Problems	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Psychiatric	Depression	☐ Yes	☐ No	Hyperactivity	☐ Yes	☐ No
	Difficulty Sleeping	☐ Yes	☐ No			
Metabolism	Weight Gain	☐ Yes	☐ No	High Blood Sugar	☐ Yes	☐ No
Blood	Anemia	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No

Allergies

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

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

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

_____

_____

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

_____

_____

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

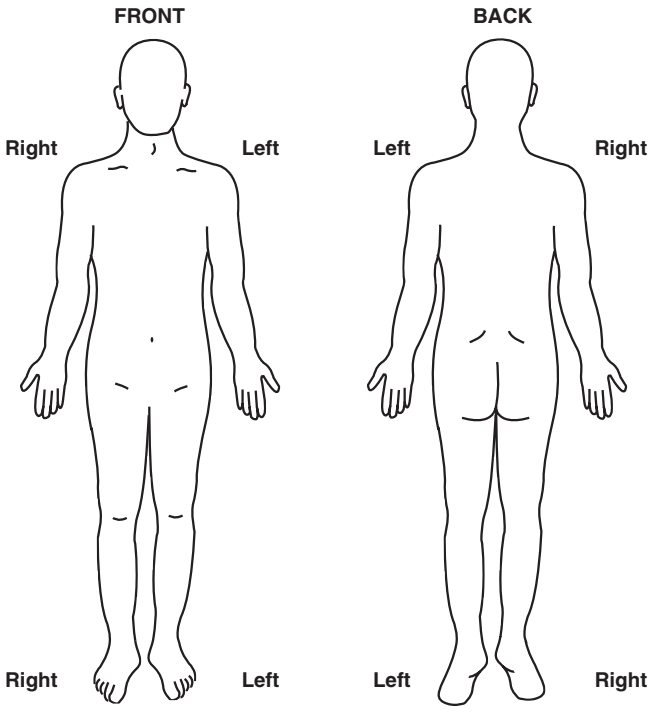
_____

_____

Pain Diagram

Using the figures to the right, mark the areas where you feel the described sensation on your body. Use the appropriate symbols *(indicated below)* and include all affected areas.

Ache	+++++++++ +++++++++
Numbness	========= =========
Pins & Needles	oooooooo oooooooo
Burning	^^^^^^^^ ^^^^^^^^
Stabbing	//////////////////// ////////////////////



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: _____

Ventura Orthopedics

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.