Patient Registration Form

California Pacific Orthopaedics & Sports Medicine

Physician you are seeing (Please ☑):

□ R. Gilbert,M.D. □ W. Green,M.D. □ T. Smith,M.D. □ J. Dickinson,M.D.
□ C. Cox,M.D. □ J. Belzer,M.D. □ K. Donatto,M.D. □ P. Callander,M.D.
□ A. Rawlinson,M.D. □ R. Paul,M.D. □ S. Green,M.D.

Demographic Information

Last Name: _____ First Name: _____ Middle: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone (_____) _____ Cell (_____) _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Age_____

Employer: _____ Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ Work Phone (_____) _____ Extension _____

Marital Status: □ Single □ Married □ Divorced □ Widow Email: _____

Name of Spouse / Partner: _____

Who is your Primary Care Physician?

Name: _____ Phone (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Phone (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____

Insurance Information

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

Name of Tertiary Insurance Company: _____

About the Policy Holder:

Full Name: _____Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____Relationship to the Patient: _____

Gender: Male _____ Female _____

For patients under the age of 18 years old, the undersigned Parent/Guardian authorizes treatment and agrees that the policy holder will be named as the account guarantor unless noted otherwise in writing.

Signature: _____ Print Name: _____

Relationship: _____ Today's Date: _____

Patient Medical History

California Pacific Orthopaedics & Sports Medicine

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ _____ Age: _____ Sex: _____Marital Status:

_____

Occupation: _____ **Primary Care Physician**: _____

Height: _____ Weight: _____ Weight one year ago: _____ Children: _____

I am: □ Left Handed □ Right Handed Who may we thank for your referral? _____

Are we seeing you in relation to an injury/accident? □ Yes □ No If yes: Date of Injury? _____

□ Automobile Accident □ Work-Related Injury □ Other _____

Are you on Disability? □ Yes □ No If yes: Last Date of Work? _____

Current Medical problems:

□ Diabetes
□ Ulcer
□ Arthritis
□ Hepatitis
□ Chest Pain
□ Asthma
□ High Blood Pressure
□ High Cholesterol
□ Bowel Disorder
□ Emphysema
□ Heart Failure
□ Thyroid Disease
□ Cancer / Type _____
□ Kidney Disease
□ Prostate Disease
□ Heart Murmur
□ HIV
□ Other: _____

1) What medications do you take routinely? (Include dosage and frequency) _____

_____

_____

2) Allergy to Medication: _____

3) Are you currently using intravenous or recreational drugs? (Include type and amount per day)

_____

4) Past Surgeries (Include type and dates): _____

_____

Do you smoke now? □ Yes □ No # of packs per day? _____ How many years? _____

If you quit smoking, how long ago? _____ # of packs per day? _____ How many years? _____

Do you drink alcohol? □ Yes □ No How may ounces per day? _____
(One 12 oz. beer or one glass of wine = 1 oz. of hard liquor)

Diet: □ High in fat / Cholesterol □ Moderate □ Low □ Vegetarian

How many times per week do you exercise? _____ What type? _____

Father: □ Alive □ Deceased Age and cause of death: _____
Mother: □ Alive □ Deceased Age and cause of death: _____
Sibling: □ Alive □ Deceased Age and cause of death: _____
Sibling: □ Alive □ Deceased Age and cause of death: _____

Are there any diseases that run in your family? _____

Date of last menstrual period: _____ Age at Menopause: _____

Review of Systems

CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE

Last Name: _____ First Name: _____ Date of Birth: _____

Please check any illness, symptoms or problems that you have had in the last month:

Constitutional
☐ Blood Pressure
☐ Respiration
☐ Fever/sweats
☐ Fatigue
☐ Loss of appetite / weight change

Eyes
☐ Eye Disease of injury
☐ Eye glasses / contact lenses
☐ Blurred / double vision
☐ Glaucoma

Ears / nose / mouth / throat
☐ Hearing loss
☐ Hearing noises in your ear
☐ Earaches and drainage
☐ Nosebleeds
☐ Trouble swallowing
☐ Bleeding gums
☐ Sore throat
☐ Snoring
☐ Voice changes
☐ Problems with thyroid

Musculoskeletal
☐ Joint pain / stiffness
☐ Muscle pain / cramps / weakness
☐ Back pain

Skin
☐ Rashes
☐ Lesions
☐ Ulcers

Cardiovascular
☐ Chest pain / angina
☐ Palpitations
☐ Shortness of breath
☐ Swelling of feet, ankles or hands
☐ Murmur

Respiratory
☐ Cough
☐ Spitting up blood
☐ Shortness of breath
☐ Wheezing

Gastrointestinal
☐ Problems with bowel movements
☐ Nausea / vomiting
☐ Rectal bleeding / blood in stool
☐ Abdominal pain / heartburn

Genitourinary
☐ Flank pain
☐ Problems with urination
☐ Blood in urine
☐ Kidney stone

Neurological
☐ Headaches
☐ Numbness / tingling sensation
☐ Tremors
☐ Head injury

Hematologic / lymphatic
☐ Slow to heal after cuts
☐ Tendency to bleed / bruise
☐ Blood clots
☐ Past blood transfusion

Other Symptoms
☐ Memory loss / confusion
☐ Nervousness / Anxiety
☐ Depression
☐ Insomnia

Completed by: _____ Relationship: _____ Today's Date: _____