PATIENT REGISTRATION

(Please Print)

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)			
HOME ADDRESS	CITY	STATE	ZIP		HOME PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	MARITAL STATUS M S D W	CELL PHONE
EMPLOYER	OCCUPATION				WORK PHONE
REFERRING PHYSICIAN (NAME, ADDRESS, PHONE)	PRIMARY CARE PHYSICIAN				

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP TO PATIENT	PHONE
ADDRESS	CITY	ZIP

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY			PHONE NUMBER
INSURANCE COMPANY ADDRESS			
SUBSCRIBER'S NAME	DATE OF BIRTH	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT
GROUP NUMBER		ID OR POLICY NUMBER	EFFECTIVE DATE

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY		
INSURANCE COMPANY ADDRESS		
SUBSCRIBER'S NAME	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT
GROUP NUMBER	ID OR POLICY NUMBER	EFFECTIVE DATE

WORK RELATED INJURIES ONLY / COMPLETE THE FOLLOWING

COMPENSATION INSURANCE CARRIER			
INSURANCE COMPANY ADDRESS		PHONE NUMBER	COMPANY PHONE NUMBER
DATE OF INJURY	WAS INJURY REPORT FILED?	NAME OF INSURANCE ADJUSTER	ADJUSTER PHONE NUMBER

PLEASE READ CAREFULLY

In order to provide you with the highest quality of affordable healthcare, we request that our charges for office visits be paid at the conclusion of each visit. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, others pay a percentage of the charge. It is your responsibility to pay any co-insurance, or any other balance not paid for by your insurance. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection, to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to the provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all necessary information to secure payment. CORE Orthopaedic Medical Center and/or physicians may have a financial or other interest in companies which manufacture or distribute some of the products that are used in the course of your treatment. If you have questions or concerns about a particular product or maunfacturer, please let your physician know.

Signature (Responsible Party):_______________________________ Date:_____/_____/_____ Acct#_____________

New Patient [ ] Update [ ]

332 SANTA FE DRIVE SUITE 110, ENCINITAS, CA 92024
PHONE: (760)943-6700 FAX: (760)632-4292
WWW.COREORTHOPAEDIC.COM

Past Medical History

Patient's name:________________________________ Date:______________

Allergies

Do you have any known drug, food, or environmental allergies?	Yes	No

Please list any allergies below:

Current Medications

List any medications you are taking, including over-the-counter medications and supplements:

Medication	Dose	How Often

Past Medical History

Do you have or have you had any of the following medical conditions?		
Hypertension (high blood pressure)	Yes	No
Heart disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic ulcers (stomach or duodenal)	Yes	No
Kidney disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

Family History

Have any of your blood relatives (living or deceased) had any of the following conditions?		
Hypertension (high blood pressure)	Yes	No
Heart disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic ulcers (stomach or duodenal)	Yes	No
Kidney disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

List other medical conditons you have below:

OB GYN for Women

Are you now pregnant?	Yes	No
How many children have you had?		
0 1 2 3 4 5 6+		

Past Surgical Procedures

List any surgical procedures you may have had in the past and your approximate age at the time:

Procedure	Age

Social History

Which best describes your situation?	
I live alone	
I live with family	
I live with friends	
I live in a structured setting with help	

What is your smoking history?	
I have never smoked	
I used to smoke	
I currently smoke	
How many packs a day?	

What is your alcohol intake?	
I do not drink alcohol	
I drink alcohol every day	
I drink once or more each week	
I drink once or more each month	
I drink rarely	

Continue on the back side

REVIEW OF SYSTEMS

Name: ___________________________ Complete - Male

Constitutional

Normal	Yes	No
Fever	Yes	No
Chills	Yes	No
Feeling poorly (Malaise)	Yes	No
Feeling Tired (Fatigue)	Yes	No
Recent Weight Gain	______	Lbs
Recent Weight Loss	______	Lbs

Eyes

Normal	Yes	No
Eye Pain	Yes	No
Red Eyes	Yes	No
Eyesight Problems	Yes	No
Discharge from Eyes	Yes	No
Dry Eyes	Yes	No
Eyes Itch	Yes	No

Ears/Nose/Throat

Normal	Yes	No
Earache	Yes	No
Loss of Hearing	Yes	No
Nosebleeds (Epistaxis)	Yes	No
Nasal Discharge	Yes	No
Sore Throat	Yes	No
Hoarseness	Yes	No

Cardiovascular

Normal	Yes	No
Chest Pain	Yes	No
Irregular Heartbeat	Yes	No
Heart Rate is Fast	Yes	No
Heart Rate is Slow	Yes	No
Leg Pain/Cramps	Yes	No
Swelling in Legs	Yes	No

Respiratory

Normal	Yes	No
Shortness of Breath: □ At Rest □ With Exercise □ While Lying Down □ During Sleep	Yes	No
Wheezing	Yes	No
Cough	Yes	No
Short Of Breath on Exertion	Yes	No
Persistent Cough	Yes	No
Cough up blood	Yes	No

Gastrointestinal

Normal	Yes	No
Abdominal Pain	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Black Stool	Yes	No

Genitourinary

Normal	Yes	No
Pain with urination	Yes	No
Incontinenence	Yes	No
Hesitancy	Yes	No
Frequent urination	Yes	No
Genital Lesion	Yes	No
Testicular Pain	Yes	No

Musculoskeletal

Normal	Yes	No
Joint Pain	Yes	No
Muscle Pain	Yes	No
Joint Swelling	Yes	No
Joint Stiffness	Yes	No
Limb Pain	Yes	No
Limb Swelling	Yes	No

Integumentary

Normal	Yes	No
Skin Leisions	Yes	No
Skin Wound	Yes	No
Skin Itching (Pruritus)	Yes	No
Change in a Mole	Yes	No
Dry Skin	Yes	No
A Unusual Growth	Yes	No

Neurological

Normal	Yes	No
Confusion	Yes	No
Convulsions	Yes	No
Dizziness	Yes	No
Fainting (Syncope)	Yes	No
Limb Weakness (Paresis)	Yes	No
Difficulty Walking	Yes	No

Psychiatric

Normal	Yes	No
Suicidal	Yes	No
Sleep Disturbances	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Change in Personality	Yes	No
Emotional Problems	Yes	No

Endocrine

Normal	Yes	No
Bulging Eyes	Yes	No
Hot Flashes	Yes	No
Muscle Weakness	Yes	No
Erectile Dysfunction	Yes	No
Deepening of the Voice	Yes	No
Feelings of Weakness	Yes	No

Heme/Lymph

Normal	Yes	No
Swollen Glands	Yes	No
Swollen Glands in the Neck	Yes	No
Easy Bleeding	Yes	No
Easy Bruising	Yes	No

Other: ____

____

REVIEW OF SYSTEMS

Name : ____________________________ Complete - Female

Constitutional

Normal	Yes	No
Fever	Yes	No
Chills	Yes	No
Feeling poorly (Malaise)	Yes	No
Feeling Tired (Fatigue)	Yes	No
Recent Weight Gain	______ Lbs	
Recent Weight Loss	______ Lbs	

Eyes

Normal	Yes	No
Eye Pain	Yes	No
Red Eyes	Yes	No
Vision Problems	Yes	No
Discharge from Eyes	Yes	No
Dry Eyes	Yes	No
Eyes Itch	Yes	No

Ear/ Nose/ Throat

Normal	Yes	No
Earache	Yes	No
Loss of Hearing	Yes	No
Nosebleeds	Yes	No
Nasal Discharge	Yes	No
Sore Throat	Yes	No
Hoarseness	Yes	No

Cardiovascular

Normal	Yes	No
Chest Pain	Yes	No
Irregular Heartbeat	Yes	No
Heart Rate is Fast	Yes	No
Heart Rate is Slow	Yes	No
Leg Pain/ Cramps	Yes	No
Swelling in Legs	Yes	No

Respiratory

Normal	Yes	No
Shortness of Breath : □ At Rest □ With Exercise □ While Lying Down □ During Sleep	Yes	No
Wheezing	Yes	No
Cough	Yes	No
Asthma	Yes	No

Gastrointestinal

Normal	Yes	No
Abdominal Pain	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Black Stool	Yes	No

Genitourinary

Normal	Yes	No
Pain With Urination	Yes	No
Incontinenence	Yes	No
Pelvic Pain	Yes	No
Painful Menstruation	Yes	No
Vaginal Discharge	Yes	No
Abnormal Vaginal Bleeding	Yes	No

Musculoskeletal

Normal	Yes	No
Joint Pain	Yes	No
Joint Swelling	Yes	No
Joint Stiffness	Yes	No
Arm/ Leg Pain	Yes	No
Arm/ Leg Swelling	Yes	No
Muscle Pain	Yes	No

Integumentary

Normal	Yes	No
Skin Lesions	Yes	No
Skin Wound	Yes	No
Skin Itching	Yes	No
Change in a Mole	Yes	No
Breast Pain	Yes	No
Breast Lump	Yes	No

Neurological

Normal	Yes	No
Confused	Yes	No
Convulsions	Yes	No
Dizziness	Yes	No
Faint	Yes	No
Leg/ Arm Weakness	Yes	No
Difficulty Walking	Yes	No
Headache	Yes	No

Psychiatric

Normal	Yes	No
Suicidal	Yes	No
Sleep Disturbances	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Change in Personality	Yes	No
Emotional Problems	Yes	No

Endocrine

Normal	Yes	No
Bulging Eyes	Yes	No
Hot Flashes	Yes	No
Muscle Weakness	Yes	No
Deepening of the Voice	Yes	No
Feelings of Weakness	Yes	No

Heme/Lymph

Normal	Yes	No
Easy Bleeding	Yes	No
Easy Bruising	Yes	No
Swollen Glands	Yes	No
Swollen Glands in the Neck	Yes	No

Other: ____

____

____

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use And Disclosure Of Your Health Information In Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities/health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.
9. Data that is collected by CORE Orthopaedic Medical Center, which does not include the identity of the patient, may be utilized for research purposes.

Your Rights Regarding Your Health Information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to CORE Orthopaedic Medical Center, P.C. at (760) 943-6700 who will have up to 30 days to comply.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to CORE Orthopaedic Medical Center, P.C. at (760) 943-6700 who will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact CORE Orthopaedic Medical Center, P.C. at (760) 943-6700. All complaints must be submitted in writing; you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician. I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices.

Signature:______________________________ Date:________________

Print Name:______________________________

General Authorization to Release Health Information

I hereby authorize the release of my personal health information to any health provider approved by my treating physician. I understand that I may cancel this authorization at anytime by notifying my treating physician in writing.

Signature:______________________________ Date:________________

Print Name:______________________________

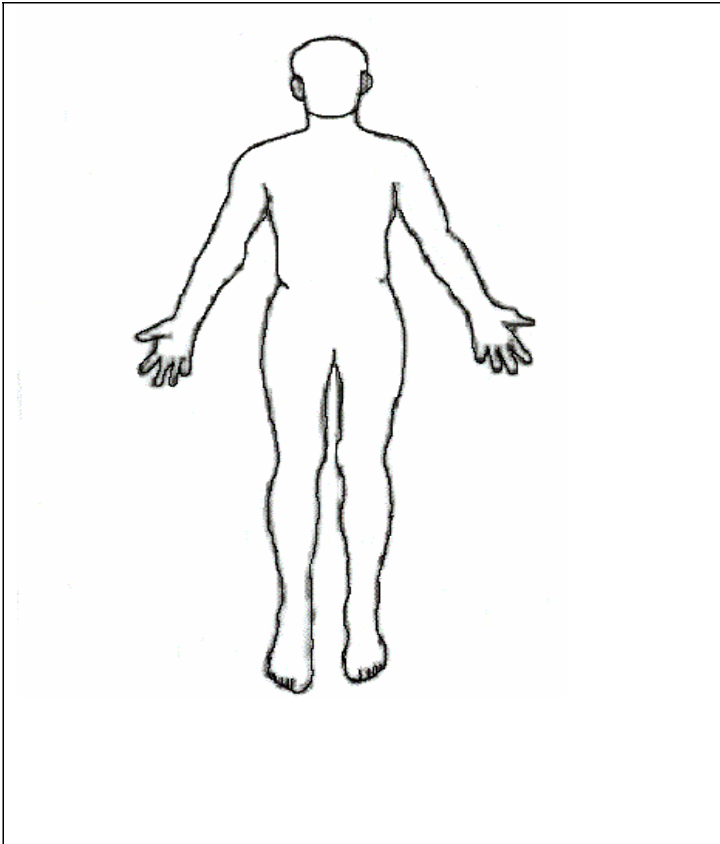
CORE ORTHOPAEDIC MEDICAL CENTER

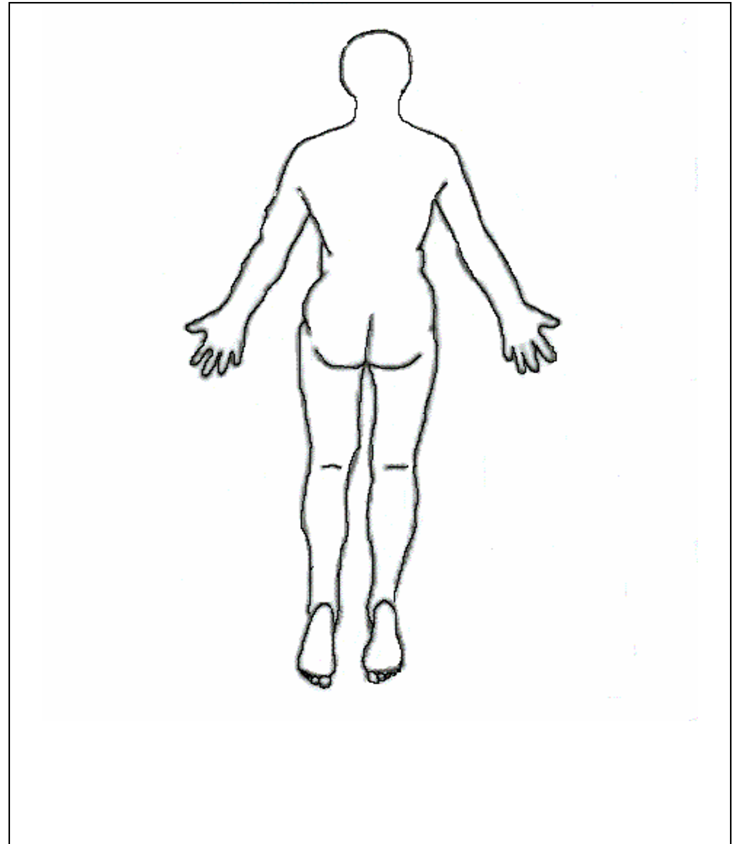
Spine Complaint Form

Patient Name:______________________________ Date:__________Age:_______ DOB:________

Mark the areas on your body where you feel the described sensations with the appropriate symbol.

(pain=xxxxxx/numbness & tingling=oooooo)





Briefly describe your problem:____

____

How and when did the problem begin?____

____

Which is more troublesome to you? □ Back Pain □ Leg Pain □ Neck Pain □ Arm Pain

How would you beak down the components of your problem?

Back	______%	Neck	______%
Right Leg	______%	Left Leg	______%
Right Arm	______%	Left Arm	______%
			Total =100%

Does the pain occur everyday?..□Yes □No

Do you have weakness in your legs?..□Yes □No

Do you have weakness in your arms?..□Yes □No

If yes, describe: ____________________

Have you noted problems with balance or equilibrium?........□Yes □No

If yes, describe: ____________________

Are you able to control bowel movements?........□Yes □No

If no, describe: ____________________

Are you able to control urination........□Yes □No

If no, describe: ____________________

Does the pain prevent sleep or awaken you at night?........□Yes □No

If yes, describe: ____________________

Have you missed time from work due to pain?........□Yes □No

What kind of work do you do? ____________________

Recreational activities include: ____________________

Has the pain interfered with your daily routine?........□Yes □No

How frequent is the pain? ....□Comes and goes □Constant

How severe is the pain now compared to when it began? ....□Better □Same □Worse

Severity of the pain is:

- □ Slight and occasional, causing no compromise in daily activities.
- □ Mild, having no effect on ordinary activity, but occurring with or after vigorous activity.
- □ Moderate and tolerable, requiring restrictions in daily activities.
- □ Severe, causing significant disability.

PLEASE INDICATE HOW THE FOLLOWING FACTORS AFFECT YOUR PAIN:	**WORSE**	**BETTER**	**NO EFFECT**
Standing	□	□	□
Walking	□	□	□
Sitting	□	□	□
Driving	□	□	□
Lying Down	□.	□	□
Nights	□	□	□
Bending	□	□	□
Lifting	□.	□	□
Rising from Chair	□.	□	□
Housework (vacuuming, making beds)	□	□	□
Coughing	□	□	□
Sneezing	□	□	□

PLEASE INDICATE PREVIOUS TREATMENT YOU HAVE RECEIVED FOR THIS PROBLEM:

□ Bedrest	□ Muscle Relaxants	□ Physical Therapy
□ Traction	□ Aspirin	□ Chiropractic Manipulation
□ Hospitalization	□ Cortisone	□ Acupuncture/Acupressure
□ Heat	□ Surgery	□ Biofeedback
□ Ice	□ Collars or Braces	□ Neurostimulator (TENS)
□ Pain Medications	□ Exercise	□ Chymopapain

□ Other ____________________

PLEASE INDICATE ANY DIAGNOSTIC TESTS YOU HAVE HAD:

□ X-Rays	□ Myelogram	□ Electromyogram (EMG)
□ CAT-scan	□ Bone Scan	□ MRI