Patient Name: ______ ____
Title First Middle Last

Home Address: ____
Street City State Zip

Email: ______________________ Language Spoken: __________ **Patient SSN**: ______________

DOB: ___/___/___ Age: _____ **Primary Phone**: ______________ (Cell)/ (Land) for text or voice message

Home Phone: (____) ___________ Cell (____) ___________ Work (____) ___________

Gender: M or F Race: ❑ White ❑ Hispanic/Latino ❑ Black/African American ❑ Decline ❑ Asian

❑ American Indian/Native Alaskan ❑ Native Hawaiian/Pacific Islander ❑ Other

Marital Status: ❑ Married ❑ Single ❑ Divorced Ethnicity: ❑ Non-Hispanic/Latino ❑ Hispanic/Latino ❑ Decline

Employer: ______________________ Occupation: ______________________

Emergency Contact: ______________ Phone: ___________ Relationship to patient: __________

CORE Physician: ______________________ Primary Care Physician: ______________________

Referring Physician: ______________________

Insurance information **Primary Insurance Co**: ______________ Relationship to insured: ________

Subscriber's Name: ______________________ Subscriber's SSN: ______________________

Member ID #: ______________ Group #: ______________ **Subscriber's DOB**: ________

Gender: M F Secondary insurance Co: ______________ Relationship to insured: ______________

Subscriber's Name: ______________________ Subscriber's SSN: ______________________

Member ID #: ______________ Group #: ______________ DOB: ________

Name of Pharmacy: ______________________ Pharmacy Phone: ______________________

I authorize the following individual(s) to receive information pertaining to my medical history or treatment:

Name: ______________________ Relationship to patient: __________

Name: ______________________ Relationship to patient: __________

FINANCIAL AGREEMENT

I authorize Core Orthopaedic Medical Center to bill my insurance for services rendered to me/my dependent. I authorize Core Orthopaedic Medical Center to release personal health information to treat me/my dependent, to receive payment for the care we provide, and for other health care operations. A detailed NOTICE OF PRIVACY PRACTICES is available upon request to help you understand our policies. The undersigned acknowledges receipt of this information. **I understand that I am financially responsible for any and all charges not covered by my insurance for any reason.** I agree to pay reasonable attorney's fees and collections fees, should the account be referred to an attorney or collection agency for collection. I understand that Core Orthopaedic Medical Center shall have the right at any time to refuse to provide medical care or treatment to me. I certify that I am the patient or am duly authorized by the patient or patient's general agent to execute this document and accept its terms.

Patient Signature: ______________________ Date: ___/___/___

Guardian Signature: ______________ **Name**: ______________ Relationship to Minor: __________

Past Medical History

Patient's Name: ___________________________________
DOB: ___________ Date:___________________

Allergies

Please list any known drug, food, or environmental allergies below

Current Medications

List any medications you are taking, including over-the-counter & supplements		
Medication	**Dose**	

Personal Medical History

Do you have or have you had any of the following medical conditions?		
Hypertension	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 conditions you have below:

OG/GYN for Women

Are you now Pregnant? YES NO
How many children have you had?
1 2 3 4 5 6+

Past Surgical procedures

List any surgical procedures you've had and your approximate age at the time	
Procedure	**Age**

Family Medical History

Have any of your blood relatives (living or deceased) had any of these conditions?		
Hypertension	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

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	

REVIEW OF SYSTEMS

NAME:____

Constitutional		
Fever	Yes	No
Chills	Yes	No
Feeling Poorly	Yes	No
Feeling Tired	Yes	No
Recent Weight Gain	_______	Lbs
Recent Weight Loss	_______	Lbs

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

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

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

Integumentary		
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

Genitourinary (FEMALE)		
Pain with Urination	Yes	No
Incontinence	Yes	No
Pelvic Pain	Yes	No
Painful menstruation	Yes	No
Vaginal Discharge	Yes	No
Abnormal Vaginal Bleeding	Yes	No

Genitourinary (MALE)		
Pain with Urination	Yes	No
Incontinence	Yes	No
Hesitancy	Yes	No
Frequent Urination	Yes	No
Genital Lesion	Yes	No
Testicular Pain	Yes	No

Musculoskeletal		
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

Neurological		
Confusion	Yes	No
Convulsions	Yes	No
Dizziness	Yes	No
Fainting (syncope)	Yes	No
Limb Weakness (paresis)		
Difficulty Walking		

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

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

Other: ____

____

HIPAA Authorization for use or disclosure of health information:

Patient Name: ______________________________ Patient D.O.B:______________

Cell Phone:______________________ Home Phone: _______________________

E-mail Address: ____

I authorize CORE Orthopaedic to leave messages with medical information on Voicemail/Answering Machine/E-mail at: (Please check)

____ Home _____ Cell Phone _____ Work _____E-mail

I authorize for the following individual(s) to receive information pertaining to any medical history or treatment received:

Name: _____________________________________ Relationship: _____________

Name: _____________________________________ Relationship: _____________

Name: _____________________________________ Relationship: _____________

In accordance with Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. **I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at (332 Santa Fe Drive, #110, Encinitas, CA 92024). My revocation will be effective once received by CORE Orthopaedics.**
2. **The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.**
3. **My authorized represenitive will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.**
4. **A copy of this authorization may be used with the same effectiveness as the original.**

This authorzation shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

Signature: ____________________________________ Date: _______________

OR Authorized Representive Name: ____________________ Relationship: _____________

Authorized Representive Signature: ___________________ Date: _______________

332 Santa Fe Drive, Suite 110, Encinitas, CA 92024
Telephone: 760-943-6700 Fax: 760-632-4292
www.Coreorthopaedic.com

MEDICAL HISTORY FORM – DR. LOREN

Name:______________________________ Date:______________

Occupation:______________ Primary Physician:____________ Referring Physician ____________

Age:________ ☐ Right ☐ Left Handed ☐ Female ☐ Male Height: __________ Weight:__________

What is the **primary body part** involved?

Shoulder	Elbow	Knee	Ankle	Hip	Wrist/Hand
☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

What is the **main** problem? ☐ Pain ☐ Stiffness ☐ Weakness ☐ Instability ☐ Swelling ☐ __________

How long ago did the symptoms start? ________ Days ________Weeks ________Months ________Years

Note any previous similar problems.______________________________

Check the **ONE BOX** which describes best how the problem started and answer the related questions. Use the comment box to provide details or explanations.

☐ **NO KNOWN INJURY**
Was the onset ☐ Gradual or ☐ Sudden?
Indicate how/why it may have started.

☐ **SPORTS INJURY**
Sport:______________ Team:________
Specify how and when the injury occurred.

☐ **OTHER INJURY**
Provide relevant details and date.

☐ **AUTO COLLISION**
☐ Driver ☐ Passenger; Seat Belt ☐ On ☐ Off
Did Air Bags Deploy? ☐ Yes ☐ No
Was car ☐ Repairable or ☐ Totaled?
Cost of Repair: $______________.
Describe details of auto accident.

☐ **WORK INJURY**
How did job duties/injury cause the problem?

COMMENTS:

Date of onset, if known:____________________

Was this problem evaluated in the Emergency Room? ☐ Yes ☐ No. Which ER? ______________ Date: __________

Describe the location of the pain. ______________________________

Additional symptoms: ☐ Swelling ☐ Bruising ☐ Numbness/Tingling ☐ Weakness ☐ Locking/Catching ☐ Giving Way

Symptoms worsened by ☐ Standing ☐ Walking ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Twisting
☐ Lifting/Reaching ☐ Exercise/Sports (specify,______________) ☐ Daily Activities __________

Is the pain ☐ Constant or ☐ Intermittent (comes and goes)? Does the pain disrupt sleep? ☐ Yes ☐ No

On a scale of 0-10 (10 being the worst), how severe is the pain? (circle) **0 1 2 3 4 5 6 7 8 9 10**

Since the onset, the problem is now ☐ Better ☐ Worse ☐ Unchanged.

What medications have been taken for this problem? ______________________ ☐ Temporary Relief or ☐ No Relief.

Any additional treatments? ☐ Injection ☐ Brace ☐ Cast ☐ Physical Therapy ☐ Cane/Crutch ☐ ______________

What tests/scan have been performed? ☐ XRay ☐ MRI ☐ CT ☐ Bone Scan ☐ Nerve Test (EMG/NCV) ☐______________

Has any surgery been performed for a problem in the same area recently or in the past? ☐ Yes ☐ No

1. Procedure______________ Surgeon______________ City____________ Date ____________
2. Procedure______________ Surgeon______________ City____________ Date ____________

Is a lawsuit pending with regard to this injury? ☐ Yes ☐ No

Additional comments:______________________________