CORE ORTHOPAEDIC MEDICAL CENTER

Patient Name: _____ _____
Title First Middle Last

Billing Address: _____
Street City State Zip

Email: _____ Language Spoken: _____ Patient SSN: _____

DOB: ___/___/___ Age: _____ Primary Phone: _____ (Cell or Land) OK to leave message (Y/N)

Secondary Phone: _____ (Cell Land Work) Gender: M or F

Race: ❑ White ❑ Hispanic/Latino ❑ Black/African American ❑ Asian ❑ American Indian/Native Alaskan

❑ Native Hawaiian/Pacific Islander ❑ Other ❑ Decline

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

Emergency Contact: _____ Phone: _____ Relationship to patient: _____

CORE Physician: _____ Primary Care Physician: _____

Referring Physician: _____

Workers' Compensation Insurance information:

Employer at time of Injury: _____ Phone#: _____

Occupation: _____

Insurance Company: _____ Address: _____

Claim #: _____ Date of Injury: _____

Adjuster: _____ Phone#: _____ Fax#: _____

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. There is a 15 minute grace period for appointment check-in. Patients who fail to cancel their appointments 24 hours in advance are subject to a $50 charge.

Patient Signature: _____ Date: ___/___/___

Guardian Signature: _____ Name: _____ Relationship to Minor: _____

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Workers' Compensation Injury History Form

Patient Name: _____ Date: _____

Job Description

Age: _____ Right / Left Handed (Circle one) Employer at the time of injury: _____

Job Title: _____ Number of hours worked: per day _____ per week _____

Basic work duties at the time of injury: _____

_____

_____

Tools/Machinery routinely used: _____

Objects you lifted alone while working: _____ Heaviest objects lifted: _____

Estimate the weight of the heaviest objects lifted: _____ Number of times a day this amount was lifted: _____

Objects lifted with co-workers each day: _____ Weight of objects: _____ Number of times lifted: _____

Length of time with this employer at the time of injury: _____ Length of time in this line of work: _____

Did you work for any other employer, for any friends, or have a home-based business on the side while working for this employer? _____

If yes, please complete the following:

Name of employer or type of home-based business: _____

Type of work performed for employer, at home, or for friends: _____

Time period you worked for other employer, friend, or at home-based business: _____

List places of employment for the last 10 years:

Employer: _____ Position held: _____ Length of time: _____

Duties performed: _____

Employer: _____ Position held: _____ Length of time: _____

Duties performed: _____

Employer: _____ Position held: _____ Length of time: _____

Duties performed: _____

If you have additional employers, please list: _____

_____

Date of Injury: _____ If there is no specific date of injury, when did you first begin to have problems? _____

What were you doing at the specific time of injury? If there was no specific injury, when did symptoms begin?

_____

_____

_____

_____

_____

What parts of your body were injured? _____

What symptoms did you have? _____

Did you continue to work? _____ If no, why not? _____

When was the injury reported? _____ To whom? _____

Place where treatment was **first** received? _____ Date of **first** treatment: _____

Course of Treatment to Date

Treatment received	Date	Physician	Location	Type	Results of Treatment
X-Rays					
MRI					
Therapy					
CAT Scan					
Myelogram					
Injections/Epidural					
Medications					
Surgery					
Chiropractic Care					
Acupuncture					
EMG/Nerve Conduction					
Other					

Which treatments helped? _____

Which physician(s) is currently treating you? _____

What diagnosis have you been given? _____

What further treatments have you been told are needed? _____

Have you been released from care by any physician? _____ If yes, when and which physician(s)? _____

Since the injury, have you returned to any type of work? _____ If yes, when did you return to work? _____

Are you working for the same employer? _____ Are you currently performing the same duties for them? _____

If you have a new employer, who is it? _____ When did you start? _____

What are your duties for the new employer? _____

If working for the same employer, what duties are you **not** performing? _____

Dates you did not work at all: From _____ to _____ From _____ to _____

Dates light duty performed: From _____ to _____ From _____ to _____

Dates full duty performed: From _____ to _____ From _____ to _____

Since the injury, have you had any other injuries that are industrial or non-industrial? _____

If yes, date of injury: _____ Was it industrial? _____ What area of the body was injured? _____

Treatment for above injury (type and where received)? _____

Present Complaints

Symptoms	Where	How Often	Worsened By	Relieved by
Pain				
Numbness				
Tingling				
Swelling/Stiffness				
Weakness				
Difficulty with balance				
Other (i.e. headaches)				

Have you had loss of bladder or bowel control? _____ If yes, please describe in detail: _____

_____

Back Pain: Increased with: Coughing _____ Sneezing _____ Bending _____ Twisting _____ Lifting _____

Standing _____ Sitting _____ Walking _____ Driving _____ Lying down _____ Nights _____

Since your initial symptoms, are you: better _____, the same _____, worse _____?

Which is most troublesome? Back pain _____ Leg pain _____ Neck pain _____ Arm pain _____

How frequent is your pain? Comes and goes _____ Constant _____

On a scale from 1-10, with 10 being the worst possible pain, describe your pain:

1	2	3	4	5	6	7	8	9	10

Past Medical History

Have you had any other **work** related injuries to the areas involved in this claim or other areas? _____ If yes:

Dates of injury: _____ Areas injured: _____ Employer at the time: _____

Treatment received, and by whom: _____

When were you released from care for this injury? _____ When was your last treatment? _____

Do you have future medical care? _____ If yes, what? _____

Did you receive a settlement for this injury? _____ If yes, how much or what percentage rating? _____

Have you had **non-work** related injuries to the areas involved in this claim or other areas? _____ If yes:

Dates of injury: _____ Areas injured: _____ Treatment received, and by whom: _____

When were you released from care for this injury? _____ When was your last treatment? _____

Did you have back/neck pain or limitations prior to your current injury? _____

Please check any of the following you currently have or have had in the past:

Condition	Yes	No	Current Treatment
Diabetes			Type:
Heart Disease			
High Blood Pressure			
Lung Problems/Asthma/TB			
Stroke/Seizures/Psychological			
Stomach/Ulcers/Bleeding			
Liver Disease			
Thyroid Disease			
Tumors/Cancer			
Kidney Problems			
Arthritis			Where:
Other			

Hospitalizations: _____

Surgeries: _____

Current medications you are taking:	Dose:	How Often:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Family History

Please list any family members who have in the past, or are currently receiving treatment for:

Condition	Relationship to you	Treatment
Diabetes		
High Blood Pressure		
Heart Disease		
Cancer		
Excessive Bleeding		
Problems with anesthesia		
Stroke		
Other		

Social History

Ethnic Background: _____ Marital Status: _____ Highest level of education completed: _____

Do you exercise regularly? If so, what? _____

Alcohol intake per day: 0 1-2 3-4 5-8 10-15 more Type of alcohol: _____

Smoking: Cigars _____ per day; Cigarettes _____ pack(s) per day for _____ years; Quit _____ years ago.

List all hobbies performed before the injury and the ones you are no longer able to do because of the injury: _____

_____

_____

Women Only

Are you currently pregnant? _____ Are you trying to become pregnant? _____

Is there a possibility you may be pregnant now? _____

When was your last menstrual period? _____

Please describe any "female" problems you are currently experiencing and the treatment you are receiving: _____

_____

_____

Family Doctor Contact Information: _____