Orthopedic Surgery

RICHARD C. ROSENBERG, M.D.

Diplomate American Board of Orthopedic Surgery

PATIENT INFORMATION

DATE___/___/____

NAME LAST_____ FIRST_____ MI___		AGE _____	BIRTHDATE ____/_____/___	SEX ☐Male ☐Female
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE		EMAIL	
MARITAL STATUS ☐Married ☐Divorced ☐Single	DRIVERS LICENSE		SOCIAL SECURITY	
EMPLOYER	OCCUPATION		WORK PHONE	
NAME OF SPOUSE (PARENT IF MINOR)			RELATION	
EMPLOYER	OCCUPATION		WORK PHONE	
EMERGENCY CONTACT				
RELATION	WORK PHONE		HOME PHONE	

INSURANCE INFORMATION

Please give a copy of your Insurance Card to our Front Desk Coordinator

YOU ARE RESPONSIBLE FOR VERIFYING YOUR INSURANCE ELIGIBILITY AND BENEFITS. PRE-CERTIFICATION DOES NOT GUARANTEE PAYMENT.

Do you have Medical coverage? ☐ Yes ☐ No

PRIMARY INSURANCE COMPANY	SUBSCRIBER NAME_____ DATE OF BIRTH___/____/___
CERTIFICATE/I.D. NUMBER	GROUP/POLICY NO.
SUPPLEMENTAL INSURANCE COMPANY	SUBSCRIBER NAME_____ DATE OF BIRTH___/___/___
CERTIFICATE/I.D. NUMBER	GROUP/POLICY NO.

Are you here because of a CURRENT injury? If so, how did it happen? _____
Where did it happen? _____ Comment _____
_____
If work related and case still pending, complete the following
Date of injury____/___/___Date Reported___/___/___ Claim #_____Case Settled: ___/___/___
Employer (at time of injury)_____ Name of Industrial Carrier _____
Adjuster's Name _____ Phone _____Email _____
Address _____Apt ____ City _____State ____ Zip _____
If you have an attorney for any injury indicated above please complete
Attorney's Name _____ Phone_____Email_____
Address _____Suite___ City_____ State ____ Zip_____
Which doctor referred you to this office? _____Phone Number_____
Who's your primary doctor? _____Phone Number_____

Authorization to pay benefits to physician: I hereby authorize payment directly to the treating physician of major medical benefits due me. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

Signed _____Date ___/____/____

We request payment for office visits at the time the service is rendered.

Tel 818.996.6800 | Fax 818.996.2929
18370 Burbank Boulevard | Suite 614 | Tarzana | California | 91356
Satellite Offices | Santa Ana | Oxnard

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MEDICAL HISTORY

DATE__/___/___ REFERRED BY_____MALE ☐ FEMALE ☐

NAME _____DATE OF BIRTH (MM/DD/YY): ____/____/____
(Last) (First) (Middle)

HEIGHT ft__ in_____ WEIGHT_____ AGE_____ RIGHT HANDED☐ LEFT HANDED☐

The medical history included here is of importance to you and your physician. Please complete each item of the following medical history and have it available for the physician when you are seen.

PRESENT ILLNESS

1. Describe the reason for your visit today

2. Did an accident or injury lead to this condition? If so, please briefly describe

3. List the date the problem/condition first occurred: (MM/DD/YY)

4. Have you received any treatment for this condition or injury yet? If so, briefly describe.

5. Describe any pain, discomfort, stiffness or other concerns you are experiencing.

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WORKER'S COMPENSATION PATIENTS ONLY

How long were you employed before the injury? _____

How long have you been off? _____

You went back to work at what company? _____

How long have you been treated? _____

Are you being treated now? _____

HAVE YOU SUFFERED FROM OR DO YOU CURRENTLY HAVE?

	YES	NO	DATE	AREA AFFECTED
BURSITIS, TENDONITIS	☐	☐		
ARTHRITIS	☐	☐		
GOUT	☐	☐		
LOWER BACK PAIN OR INJURY	☐	☐		
NECK PAIN OR INJURY	☐	☐		
LEG/ARM PAIN OR INJURY	☐	☐		
FRACTURES	☐	☐		
SPINE OR JOINT SURGERY	☐	☐		
DIABETES	☐	☐		
BLEEDING DISORDERS	☐	☐		
PEPTIC ULCER	☐	☐		
WEIGHT LOSS/GAIN	☐	☐		
MEDICATIONS (Dose and Frequency)	☐	☐		
ALLERGIES To Medications	☐	☐		
To Food	☐	☐		
To Dust, Pollen, Etc.	☐	☐		
PRIOR OPERATIONS	☐	☐		
SERIOUS ILLNESSES REQUIRING HOSPITALIZATION	☐	☐		
FIBROMYALGIA	☐	☐		

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SOCIAL AND FAMILY HISTORY

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Are you currently pregnant? ☐ Yes ☐ No

Number of Children _____ Ages _____

	YES	NO	TYPE	FREQUENCY
DO YOU SMOKE?	☐	☐		
DO YOU DRINK?	☐	☐		
DO YOU DO SPORTS ACTIVITIES?	☐	☐		
DO YOU JOG?	☐	☐		
DO YOU DO AEROBICS?	☐	☐		
DO YOU WEIGHT LIFT?	☐	☐		
OTHER?	☐	☐		

Does your job require any repetitive activities? Yes ☐ No ☐
Please briefly describe

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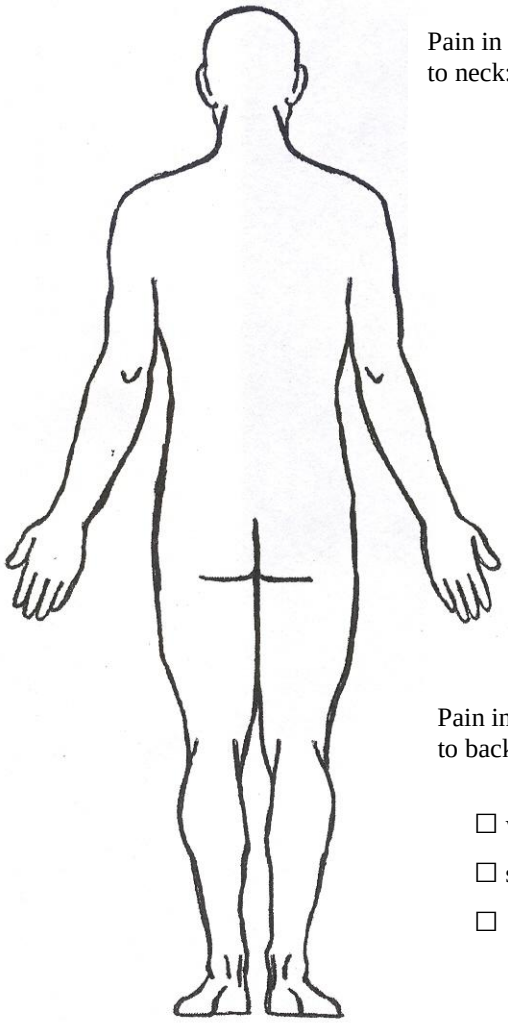
Patient Pain Drawing

Patient Name_____ Date_____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.

Ache	Numbness	Pins and Needles	Burning	Stabbing
Δ Δ Δ Δ Δ	= = = = =	o o o o o o	x x x x x	/ / / / / /

Back



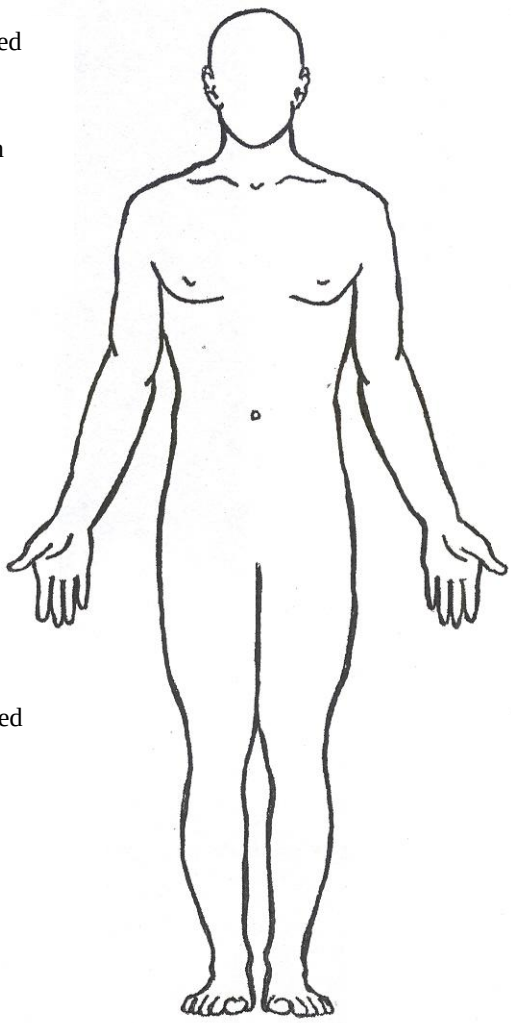
Pain in arm(s) compared to neck:

☐ worse than

☐ same as

☐ less than

Front



Pain in leg(s) compared to back:

☐ worse than

☐ same as

☐ less than

Signature _____Date _____

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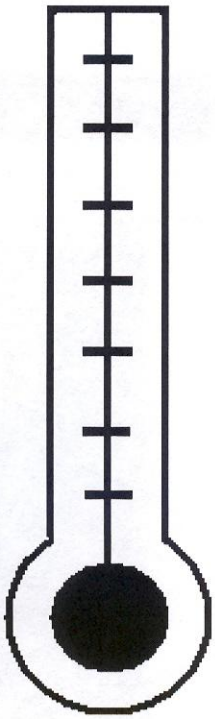
Pain Rating Scale

Patient Name: _____ **Date:** _____

Here is a thermometer with various grades of pain from "no pain at all" at the bottom to the pain is "almost unbearable" at the top. We want you to put a check by the phrase that describes your pain best. **Please rate your pain over the last month**.



☐ Pain is almost unbearable

☐ Very bad pain

☐ Quite bad pain

☐ Moderate pain

☐ Little pain

☐ No pain at all

Signature: _____ Date: _____

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