

Patient Registration Form

CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE

Physician you are seeing (Please):

J. Callander, M.D.	F. Bost, M.D.	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.			

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: _____ Ins. ID# _____
Name of Secondary Insurance Company: _____ Ins. ID# _____
Name of Tertiary Insurance Company: _____ Ins. ID# _____

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 policyholder 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	High Blood Pressure	Cancer / Type _____
Ulcer	High Cholesterol	Kidney Disease
Arthritis	Bowel Disorder	Prostate Disease
Hepatitis	Emphysema	Heart Murmur
Chest Pain	Heart Failure	HIV
As thma	Thyroid Disease	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: _____