Corona Temecula Orthopaedic Associates
MEDICAL GROUP INC.

INDUSTRIAL

Provider you will be seeing:

Physician
☐ Baum, Bradley L. ☐ Rouhe, Richard L.
☐ Locke, John S. ☐ Tooma, Ghassan S.
☐ Roghani, Reza

Physician Assistant
☐ Andrew Shaw ☐ Demetrio Quismorio, Jr.
☐ Carl McPherson, III ☐ Joseph Robles

341 Magnolia Avenue, Suite 101
Corona, CA 92879
(951) 735-6060
www.CTOAMG.com

28078 Baxter Road, Suite 330/340
Murrieta, CA 92563
(951) 677-2157
Fax (951) 735-4510

PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE
PRIMARY ADDRESS		SEX ☐ *MALE* ☐ *FEMALE*
CITY, STATE, ZIP		
EMAIL ADDRESS		
PHONE ☐ *HOME* ☐ *CELL* ☐ *OTHER*		EMERGENCY CONTACT NAME
PHONE ☐ *HOME* ☐ *CELL* ☐ *OTHER*		BIRTHDATE Relationship to Patient
MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed		PHONE ☐ *HOME* ☐ *CELL* ☐ *OTHER*
PRIMARY CARE PHYSICIAN		PRIMARY CARE PHONE
PHARMACY NAME & LOCATION		PHARMACY PHONE

EMPLOYER INFORMATION

EMPLOYER	EMPLOYER CONTACT NAME & NUMBER
ADDRESS	
CITY, STATE, ZIP	
WORK PHONE	
DATE OF ACCIDENT	
BODY PART	
W/C INSURANCE CO NAME	PHONE #
CLAIM #	

ATTORNEY INFORMATION

ATTORNEY/FIRM NAME
ADDRESS
PHONE
FAX

OPTIONAL

RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Latino/Hispanic ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Multiple ☐ White ☐ Refuse to report

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Refuse to report

LANGUAGE: ☐ English ☐ Spanish ☐ Other (Please specify):

SIGNATURE OF PATIENT

DATE

Corona Temecula Orthopaedic Associates
MEDICAL GROUP INC.

341 Magnolia Avenue, Suite 101
Corona, CA 92879
(951) 735-6060 • (951) 735-4510 *Fax*
www.CTOAMG.com

28078 Baxter Road, Suite 330
Murrieta, CA 92563
(951) 677-2157

WORKER'S COMPENSATION HISTORY FORM

NAME (Last, First, Middle Initial)		Date of Birth	Age
Exam Date	Date of Injury	Sex ☐ Male ☐ Female	
Job Title		Current Employer	

CHIEF COMPLAINT

Body part being seen for	Employer at time of injury/ Address of company

JOB HISTORY (Last 5 years)

COMPANY	POSITION	DATES OF EMPLOYMENT

HISTORY OF INJURY

Please describe how you were injured in detail.

Name of any witnesses

To whom did you report the injury?

What specific body part(s) was/were injured?

Describe your symptoms

Were you able to continue working? ☐ Yes ☐ No

Were you doing your regular work at the time of injury? ☐ Yes ☐ No

If not, what were you doing?

Were you sent to a doctor immediately? ☐ Yes ☐ No

If not, please explain:

If yes, did you drive or did someone take you?

INITIAL TREATMENT PROGRAM

Name of doctor of clinic where you were first seen

Date of first visit if not the same as the date of injury

Were x-rays taken ☐ Yes ☐ No What body parts?

Were you given medication? ☐ Yes ☐ No Name of medication(s):

Did you receive physical therapy? ☐ Yes ☐ No How often?

Did the symptoms clear up? ☐ Yes ☐ No Which ones?

Were you referred to another doctor? ☐ Yes ☐ No By whom?

Doctor's Name	Location

What did they do for you?

Please list names and dates of all other physicians seen for this injury:

Dates and results of any special tests (EMG, MRI, CT, etc.)

PRESENT TREATMENT

Who is your current doctor?

Date last seen: | What are you being treated for?

Have you had any reinjuries? ☐ Yes ☐ No What and when?

PRESENT COMPLAINTS

List all parts of your body where you have symptoms:

Do you have pain? ☐ Yes ☐ No Where?

Is your pain? ☐ Sharp ☐ Dull ☐ Aching

Is your pain? ☐ Occasional ☐ Frequent ☐ Constant ☐ Mild ☐ Slight ☐ Moderate ☐ Severe

On a scale of 1-10 (10 being the worst pain imaginable) please rate your pain at its worst: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have any of the fol[illegible]

Numbness? ☐ ☐ [illegible]here?

Tingling? ☐ ☐

Corona Temecula Orthopaedic Associates MEDICAL GROUP INC.

Stiffness? ☐ Yes ☐ No Where?

Weakness? ☐ Yes ☐ No Where?

Swelling? ☐ Yes ☐ No Where?

Popping? ☐ Yes ☐ No Where?

Grinding? ☐ Yes ☐ No Where?

Locking? ☐ Yes ☐ No Where?

Giving Way? ☐ Yes ☐ No Where?

Deformity? ☐ Yes ☐ No Where?

Radiation of pain? ☐ Yes ☐ No Where?

Bowel or bladder problems? ☐ Yes ☐ No

What makes the pain worse?

What makes the pain better?

Since the injury, has the problem gotten: ☐ Worse ☐ Better ☐ Same

Have you had a previous **WORK-RELATED** INJURY? ☐ Yes ☐ No When?

If yes, please describe:

Who was your employer at the time of the injury?

Did you fully recover? ☐ Yes ☐ No

Did you have surgery? ☐ Yes ☐ No If yes, please explain:

Did you receive a permanent disability settlement? ☐ Yes ☐ No

Have you had a previous **NON-WORK** RELATED INJURY? ☐ Yes ☐ No When?

If yes, please describe:

Did you fully recover? ☐ Yes ☐ No

Have you had ever injured the same body part that you are being seen for today? ☐ Yes ☐ No

If yes, please explain:

Did you fully recover? ☐ Yes ☐ No

List all other medical conditions: _____

SOCIAL HISTORY

Level of education (highest grade completed):

WORK STATUS

Do you have more than one employer? ☐ Yes ☐ No If yes, what is the name of the company?

Are you currently working? ☐ Yes ☐ No If yes, regular or modified work? ☐ Regular ☐ Modified

If modified, what restrictions were given?

Please list dates you missed work From: To:

Are you still employed? ☐ Yes ☐ No If yes, where are you working?

New job? ☐ Yes ☐ No If so, start date?

JOB DESCRIPTION

Describe daily job duties at the time of injury:

_____

_____

_____

_____

Mark your usual work duties prior to your injury with the following letters:
☐ **N -** Not at all ☐ **O** - Occasionally (25%) ☐ **F** - Frequently (30-75%) ☐ **C** - Constantly (80% or more)

Stand	Kneel	Reach	Bend	Walk	Climb
Stoop	Twist	Push	Pull	Squat	Drive vehicle

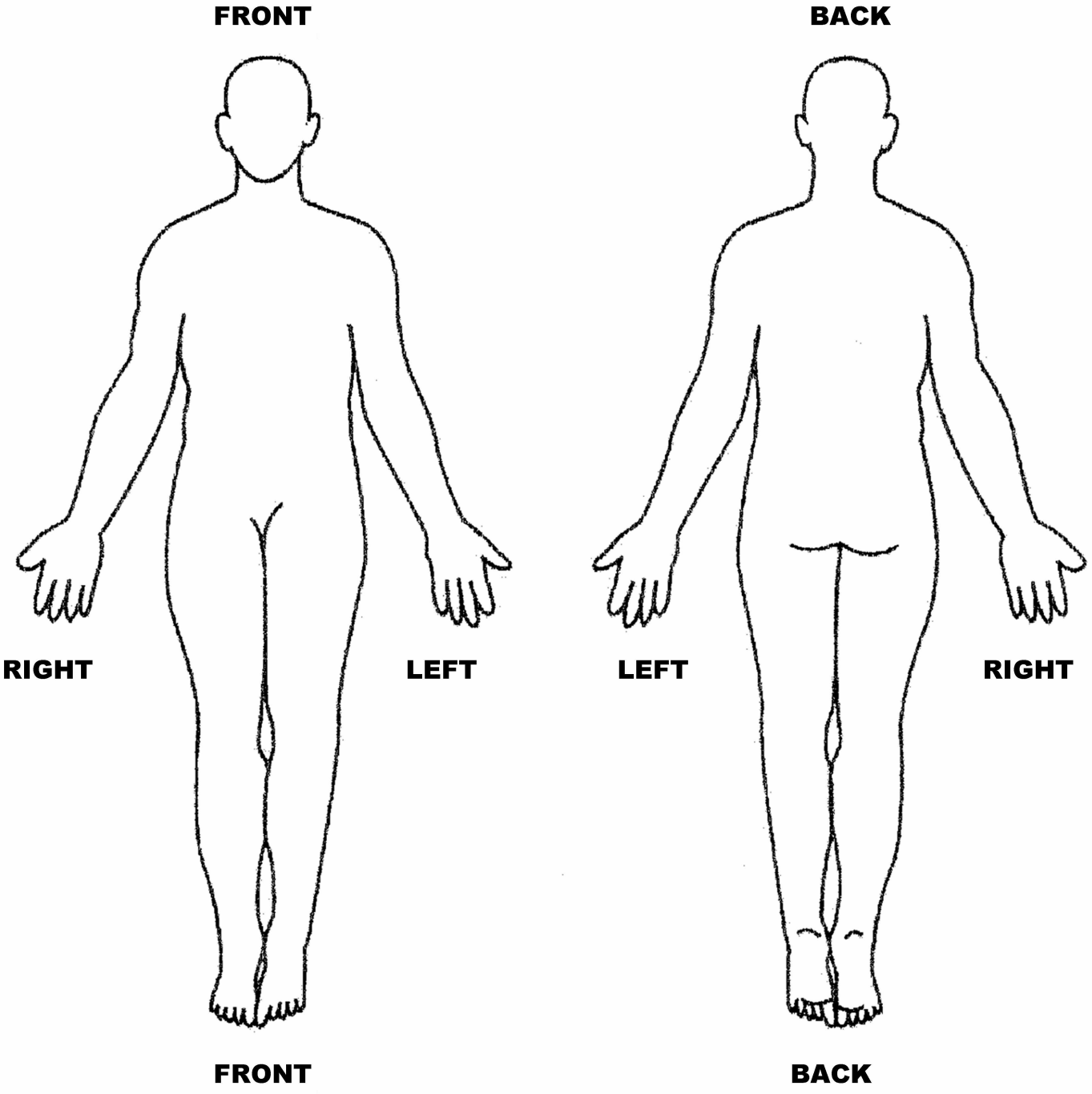
Overhead work	Detailed handwork	Exposure to dust
Computer/keyboarding _____	How many hours per day?	Exposure to noise
Lift an average weight of _____ lbs		Exposure to gas
Maximum weight of _____ lbs		Exposure to fumes
Prior to your injury, what was your work schedule?		Hours worked per day:

Days per week?	Overtime? ☐ Yes ☐ No	

PAIN DRAWING GRID ASSESSMENT

Please mark the areas where you experience the following sensations:

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
^^^^	XXXX	OOOO	= = = =	/ / / /



Corona Temecula Orthopaedic Associates
MEDICAL GROUP INC.

PATIENT MEDICAL HISTORY

Date: _____ Who sent you to our office? _____

Patient's Name: _____ SSN: _____ Sex: ☐ M ☐ F

Date of Birth: _____ Age: _____ ☐ Right-handed ☐ Left-handed Height: _____ Weight: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

CHIEF COMPLAINT

Reason for your visit: _____ Date of Injury: _____

Did you have an injury? Explain: _____ Where? _____

Current problem is the result of: (Check all that apply) ☐ Car accident ☐ Work Accident ☐ Other: _____

Is there a third-party insurer involved: ☐ Yes ☐ No Name of auto insurance: _____

Auto insurance name & address: _____

Have you had X-rays? ☐ Yes ☐ No Where: Date:

PATIENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY)

☐ Diabetes
☐ Insulin Dependent ☐ Dialysis
☐ High Blood Pressure
☐ Cholesterol Problems
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blackouts/Fainting ☐ Seizures
☐ Bleeding Disorder
☐ Cancer _____
☐ COPD
☐ Concussion(s)
☐ Depression
☐ Gastroesophageal Reflux Disease (GERD)
☐ Gout
☐ Heart Disease
☐ Heart Attack ☐ Stroke ☐ Stent ☐ Defibrillator ☐ Pacemaker
☐ Hepatitis _____
☐ Hormone Replacement Therapy
☐ Kidney Problems
☐ Lung Disease
☐ Migraines
☐ Numbness & Tingling
☐ Obesity
☐ Psychological Problems _____
☐ Repeated Infections
☐ Seasonal Allergies
☐ Sleep apnea ☐ Use CPAP
☐ Thyroid Disease
☐ **Other** _____
☐ **NO PERTINENT PAST MEDICAL HISTORY**

LIST **ALL** ALLERGIES INCLUDING MEDICATION ALLERGIES: _____

Allergy to LATEX? ☐ **Yes** ☐ **No** Allergy or reaction to metal? ☐ **Yes** ☐ **No** If yes, which? _____

FAMILY HISTORY

Has any **blood relative** had any of the following? **Please enter relationship.**

☐ Arthritis _____
☐ Anemia _____
☐ Leukemia _____
☐ Bleeding disorder _____
☐ Repeated infections _____
☐ Crippling infections _____
☐ Chronic lung disease _____
☐ Tuberculosis _____
☐ Heart Disease _____
☐ Hypertension _____
☐ Kidney disease _____
☐ Asthma _____
☐ Allergies _____
☐ Mental Illness _____
☐ Migraines _____
☐ Diabetes _____
☐ Gout _____
☐ Cancers _____
☐ Ulcers _____
☐ Thyroid problems _____
☐ Obesity _____

Patient's Initials: _____ **Reviewed by:** _____

---Please complete 2nd page ---►

SOCIAL HISTORY

☐ Employed (Occupation: _____) ☐ Work in home ☐ Student ☐ Daycare ☐ Retired

☐ Single ☐ Married ☐ Divorced ☐ Widowed Children: ☐ No ☐ Yes #_____

Do you live alone? ☐ Yes ☐ No If NO, who do you live with? ☐ Spouse ☐ Children ☐ Parents ☐ Other _____

Exercise: ☐ Daily ☐ 1-3 times/week ☐ 4-6 times/week ☐ Inactive

What type of exercise? _____

Special Interests or Hobbies: _____

Eating habits: ☐ Good ☐ Fair ☐ Poor Explain: _____

History of substance abuse: ☐ Yes ☐ No If YES, explain: _____

Smoke Currently ☐ No ☐ Yes If YES, how many a day: _____ For how many years? _____

Quit smoking: ☐ This year ☐ 1 year ago ☐ 5 years ago ☐ Longer: _____ ☐ **NEVER SMOKED**

Drink Alcohol: ☐ No ☐ Yes If YES, how much per day: _____

MEDICATIONS – PLEASE LIST CURRENT MEDICATIONS

Medication	Strength	Frequency	Reason for Medication

SURGICAL HISTORY – PLEASE LIST

Type of Surgery	Month/Year

Do you have an advanced directive, durable power of attorney for health care or living will? ☐ Yes ☐ No

If yes, may we have a copy for our records? ☐ Yes ☐ No

Any additional information: _____

_____

_____

_____

_____

Patient/Parent Signature _____ ***Date***_____

Reviewed by: _____ Date_____

Corona Temecula Orthopaedic Associates
MEDICAL GROUP INC.

I have been offered a copy of the current Notice of Privacy Practices and understand a current Notice of Privacy Practices is available at my appointments and at www.CTOAMG.com.

Patient Name: _____ Date of Birth: _____

Signature: _____

Relationship to Patient if not "Self": _____ Date: _____

Instructions for Communicating Protected Health Information (PHI)

Please indicate which of the following numbers and/or email address we should use to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers, you want us to call. Please specify if a message can be left on voicemail or with a designated person.

Cell _____ Message: *Yes* / *No*

Home _____ Message: *Yes* / *No*

Work _____ Message: *Yes* / *No*

Please note: *Emailing medically sensitive information can result in privacy breaches out of our control. For secure messaging, please join our patient portal at www.ctoamg.com.*

Email _____ *My initials indicate I understand the risks* _____

My Protected Health Information may be communicated to:

_____

_____

_____

Do not communicate my Protected Health Information to:

_____

_____

_____

Initials: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of receipt of Notice of Privacy Practices but was unable to do so as documented below:

Date: _____ Employee Initials: _____

Reason: _____