PATIENT INFORMATION

PATIENT NAME: _____

ADDRESS: _____
(CITY, STATE, ZIP)

HOME PHONE #: _____ CELL # _____ WORK #: _____

DATE OF BIRTH: _____ SS# _____ SEX: (circle one) FEMALE MALE

RACE: _____ ETHNICITY: _____ E-MAIL: _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one)
SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: _____

RESPONSIBLE PARTY INFORMATION

RESP. PARTY NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____ SS# _____ SEX: (circle one) FEMALE MALE

HOME PHONE #: _____ CELL #: _____ WORK # _____

PRIMARY INSURANCE COMPANY:

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____

SECONDARY INSURANCE COMPANY:

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

PLEASE NOTE: If there is any question regarding the bill, the person who is registering today will be responsible for payment. If patient is a minor, the person registering for the patient will be responsible.

RELEASE STATEMENT:

1. I authorize ALLAN M. DELMAN, MD and his staff to perform diagnostic tests and provide treatment necessary for medical evaluation and health care for the above mentioned patient.
2. I accept responsibility for all charges incurred in the medical evaluation and health care of the above-named patient.
3. I understand that ongoing primary medical care if the responsibility of the referring physician or another physician of my choice; it is not the responsibility of ALLAN M. DELMAN, MD.
4 I hereby give permission to ALLAN M. DELMAN, MD to provide relevant medical information about the above-named patient to _____
(Name and address of referring physician, clinic, or hospital.)

Signed _____ Date _____

PATIENT MEDICAL HISTORY

NAME _____ DATE _____

AGE _____ OCCUPATION _____

IF A MINOR: NAME OF SCHOOL _____ GRADE LEVEL _____

1. **WERE YOU INVOLVED IN AN ACCIDENT?** ☐ YES ☐ NO

   IF YES: TYPE _____(i.e. AUTO, AT WORK, SPORTS, etc.) DATE_____

   WAS THERE A THIRD PARTY INVOLVED? ☐ YES ☐ NO

   DESCRIBE WHAT HAPPENED

   _____

   _____

   _____

2. **WHAT IS THE REASON FOR YOUR VISIT?**

SYMPTOM	YES	NO
NECK PAIN		
MID BACK PAIN		
LOW BACK PAIN		
TAILBONE PAIN		

	YES	NO	RIGHT	LEFT
PAIN RADIATING TO ARMS				
PAIN RADIATING TO LEGS				
SHOULDER PAIN				
ARM PAIN				
ELBOW PAIN				
FOREARM PAIN				
WRIST OR HAND PAIN				
PELVIS PAIN				
HIP OR GROIN PAIN				
THIGH PAIN				
KNEE PAIN				
LEG PAIN				
ANKLE OR FOOT PAIN				
NUMB IN ARMS				
NUMB IN LEGS				
POOR BALANCE				
DIFFICULTY WALKING				
DIFFICULTY SLEEPING				

PLEASE ANSWER THE FOLLOWING AND WHERE APPROPRIATE CHECK ALL THAT APPLY.

WHAT IS THE LOCATION OF YOUR PAIN OR PROBLEM (i.e. FRONT OF MY SHOULDER OR LOW BACK GOING INTO MY LEG)_____

_____

WHAT IS THE QUALITY OF YOUR PAIN (CHECK EACH THAT APPLY)

___SHARP ___DULL ___THROBBING ___STABBING ___BURNING ___ACHING

WHAT IS THE TIMING OF YOUR PAIN

___DOESN'T MATTER-WITH EVERYTHING ___WITH ACTIVITY ONLY
___IN MORNING ___IN EVENING ___WHEN SLEEPING
___AT DIFFERENT TIMES

IS YOUR PAIN OR PROBLEM

___GETTING BETTER ___GETTING WORSE ___STAYING THE SAME
___RECURRENT (WENT AWAY AND CAME BACK)
___GETS BETTER AND WORSE

MY PAIN OR PROBLEM IS ASSOCIATED WITH (CHECK ALL THAT APPLY)

___BRUISING ___SWELLING ___NUMBNESS ___TINGLING ___INSTABILITY
___GIVING OUT ___LOCKING ___STIFFNESS

HOW LONG HAVE YOU EXPERIENCED THESE SYMPTOMS?

DATE STARTED _____
OR HOW MANY - DAYS _____ ; WEEKS _____; MONTHS _____ ; YEARS_____

HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS

___CONSTANT (100%) ___FREQUENT (75%) ___INTERMITTENT (50%)
___OCCASIONAL (33%) ___INFREQUENT ___ONLY WITH CERTAIN ACTIVITIES
OTHER (DESCRIBE)_____

SEVERITY: RATE THE PAIN BETWEEN 0 AND 10 0=NO PAIN 10=SEVERE
PLEASE CIRCLE: 0 1 2 3 4 5 6 7 8 9 10

MY SYMPTOMS ARE MADE BETTER BY: ___REST ___SITTING ___STANDING
___WALKING ___LYING DOWN ___OTHER-(DESCRIBE)_____

MY SYMPTOMS ARE MADE WORSE BY: ___REST ___SITTING ___STANDING
___WALKING ___ LYING DOWN ___OTHER(DESCRIBE)_____

THE PAIN IS WORSE AT NIGHT: YES NO (PLEASE CIRCLE)

THE PAIN AWAKENS ME AT NIGHT: YES NO (PLEASE CIRCLE)

FOR THIS PROBLEM I HAVE ALREADY HAD:

	YES	NO
X-RAYS		
CT OR MRI SCAN		
PHYSICAL THERAPY		
SURGERY		

PAST MEDICAL HISTORY

CHECK PREVIOUS OR CURRENT MEDICAL CONDITIONS:

___ANEMIA
___ARTHRITIS (TYPE _____)
___ASTHMA
___BLEEDING DISORDERS
___BLOOD CLOTS/DVT
___CANCER (TYPE_____)
___COPD/LUNG DISEASE
___DEPRESSION
___DIABETES
___HEART ATTACK
___HEART DISEASE
___IRREGULAR HEARTBEAT
___HEPATITIS (TYPE_____)
___HIGH BLOOD PRESSURE
___HIV/AIDS
___LIVER DISEASE
___OSTEOPOROSIS
___PROSTATE
___ULCER
___STROKE
___SEIZURES
___THYROID DISEASE
___TUBERCULOSIS
___NONE OF THE ABOVE

SURGICAL HISTORY:

☐ NONE

SURGERIES	DATES

MEDICATIONS

☐ NONE

MEDICATIONS	DOSAGE

HAVE YOU EVER TAKEN NONSTEROIDAL ANTI-INFLAMMATORY MEDICATION (SUCH AS ADVIL OR ALEVE)? YES NO

HAVE YOU EVER HAD A BAD REACTION TO ASPIRIN OR NONSTEROIDAL ANTI-INFLAMMATORY MEDICATION (I.E. ALLERGY, UPSET STOMACH OR OTHERS)?
YES NO **IF YES:** WHAT KIND OF REACTION? _____

ALLERGIES:

☐ NONE

MEDICATION	DESCRIBE REACTION (i.e., rash, difficulty breathing, hives, etc.)

ARE YOU ALLERGIC TO:

	YES	NO
IODINE		
LOCAL ANESTHETICS		
TAPE		
LATEX		

SOCIAL HISTORY

	NOW (YES or NO)	IN THE PAST (YES or NO)	CIRCLE WHICH APPLY
TOBACCO			**NOW:** EVERY DAY SOME DAY **FORMER:** EVERY DAY SOME DAYS
ALCOHOL			**NOW:** SOCIAL MODERATE EXCESS **PAST:** SOCIAL MODERATE EXCESS
DRUGS (NON-PRESCRIPTION)			

HAVE YOU EVERY BEEN IN A DRUG OR ALCOHOL TREATMENT PROGRAM?
☐ YES ☐ NO **IF YES:** WHEN? _____

FAMILY HISTORY:

___ MARRIED ___ SINGLE ___ WIDOW/WIDOWER ___ DIVORCED
___ SEPARATED ___ DOMESTIC PARTNER

CHILDREN: ___ YES ___ NO HOW MANY? _____

ANY MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY:

_____

1. **REVIEW OF SYSTEMS** - ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)
   1. **GENERAL-** ___ fatigue ___weight gain ___weight loss ___fever ___chills ___insomnia
   2. **EYES-** ___corrected lenses ___blurred/double visions ___eye pain ___eye redness ___watering
   3. **ENT-** ___headache ___difficulty swallowing ___nose bleeds ___ringing in ears ___earaches
   4. **CARDIOVASCULAR-** ___chest pain ___palpitations ___fainting ___murmurs
   5. **RESPIRATORY-** ___cough ___shortness of breath ___wheezing ___tightness ___inspiration pain ___snoring
   6. **GASTROINTESTINAL-** ___heartburn ___ nausea ___vomiting ___constipation ___diarrhea ___bloody stools
   7. **SKIN-** ___skin changes ___poor healing ___rash ___itching ___redness
   8. **GENITOURINARY-**___frequent urination ___difficulty to urinate ___painful to urinate ___bloody urine ___flank pain
   9. **NEUROLOGIC-** ___headache ___dizziness ___seizures ___tremor ___numbness/tingling ___unsteady gait
   10. **PSYCHIATRIC-** ___depression ___anxiety ___ mood swings ___stress ___hallucinations
   11. **ENDOCRINE-** ___excessive thirst ___excessive urination ___heat intolerance ___cold intolerance
   12. **HEMATOLOGIC-** ___easy bruising ___easy bleeding ___anemia ___blood clots
   13. **IMMUNOLOGIC-** ___seasonal allergies ___food allergies ___frequent infection
   14. **MUSCULOSKELETAL-** ___joint pains ___swelling ___instability ___stiffness ___muscle pain ___redness ___heat

   ___NONE OF THE ABOVE

PLEASE WRITE IN THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE PHARMACY YOU USE: _____

NAME OF PRIMARY CARE PHYSICIAN:_____

ALLAN DELMAN, M.D.
A Medical Corporation

1294 W 6th Street, Suite 210
San Pedro, CA 90731
TEL: 310.514.2453 Fax: 310.514.1726

PATIENT CONTACT INFORMATION/RESTRICTION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of the their home. I wish to be contacted in the following manner (Check all that apply):

_____ **Home Telephone** _____
_____ OK to leave message with detailed information.
_____ _____ Leave a message with call back number only.

_____ **Cell Telephone** _____
_____ Ok to leave message with detailed information.
_____ Leave message with call back number only.

_____ **Work Telephone** _____
_____ Ok to leave message with detailed information.
_____ Leave message with call back number only.

_____ **Written Communication**_____
_____ Ok to mail to my home address
_____ Ok to fax to _____

_____ **Other** _____

I hereby consent to the release of Protected Health Information to the following individuals. I understand this authorization will be effective until which time it is revoked.

NAME _____ RELATIONSHIP _____

_____ _____

_____ _____
Patient's Guardian Signature Date

_____ _____
Print Name Birthdate

ALLAN M. DELMAN M.D.
A Medical Corporation

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Allan M. Delman, M.D. to use and disclose my Protected Health Information for the purposes of treatment, payment and health care operation.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your Protected Health Information. You have the right to review our **Notice of Privacy Practices** before you sign this consent.

We reserve the right to change the terms of our **Notice of Privacy Practices.** You may obtain a copy of the current notice by requesting a copy at our Front Office desk or by calling our office at (310) 514-2453 to request a copy.

You have the right to request us to restrict how we use and disclose your Protected Health Information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you on your behalf, and delivered to the address at the bottom of this form. You may deliver your revocation by any means your choose (e.g. personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Signed:_____ Date:_____

PRINT name of patient:_____

If you are signing as the patient's representative:

PRINT your name: _____

Describe your authority to represent the patient: _____

PATIENT OR GUARDIAN TO BE PROVIDED WITH A COPY OF SIGNED AUTHORIZATION.

My written revocation must be submitted to the Privacy Officer at:
Allan M. Delman, M.D. Orthopaedic Surgeon

Address for revocation: Your revocation will be effective once it is received at the following address:

Allan M. Delman, M.D.
Orthopaedic Surgeon
1294 W 6th Street, Suite 210
San Pedro, California 90404