Pacific Pain Physicians
R. Michael Hullander, M.D. **Ralph Mozingo, D.O**
David Pires, D.O. **Daniel Roshan, M.D.**
Phone 805-563-0363 Fax 805-563-0364

PATIENT REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST,FIRST, MIDDLE INITIAL)			ADDRESS	
CITY,STATE	ZIP		HOME PHONE	WORK PHONE
PATIENT SSN	PATIENT DOB	SEX o Male o Female	Marital Status o Single o Married o Other_____	Age
PATIENT EMPLOYER NAME			PATIENT EMAIL ADDRESS (For notification of appointments/medications)	
SYMPTOMS AND COMPLAINTS:				
INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT:				
NAME (FIRST-LAST-MIDDLE INITIAL)			ADDRESS (if different from patient)	
Home Phone	Work Phone	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:		ADDRESS (STREET, CITY, STATE, ZIP)		DATE OF BIRTH OF INSURED
PHONE#	GROUP NUMBER	SUBSCRIBER ID NUMBER	NAME OF INSURED	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE NAME:		ADDRESS (STREET, CITY, STATE, ZIP)		DATE OF BIRTH OF INSURED
PHONE#	GROUP NUMBER	SUBSCRIBER ID NUMBER	NAME OF INSURED	RELATIONSHIP TO PATIENT

HOW DID THE INJURY OCCUR:	ACCIDENT RELATED? ___NO ____YES If yes type: __Auto ___Industrial ____Other Date of accident:_____ Accident in what state:_____ Is the accident employment related? Yes No		
REFERRED BY:	YOUR EMPLOYMENT STATUS: ___Full Time ____Part Time ___Retired ____Other	If you are a student: __Full time __Part time Name of school:	
NEAREST RELATIVE NOT LIVING WITH YOU:	ADDRESS:	PHONE NUMBER:	
IN CASE OF EMERGENCY CONTACT:	RELATIONSHIP:	PHONE NUMBER:	
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?			THE CO-PAY DUE TODAY IS $_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Date:_____Signature:_____

(Patient or, if minor (Signature of parent of guardian)

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PATIENT INFORMATION & HISTORY

Last Name	First Name	Middle
Date	Age	Primary Care Physician:

CHIEF COMPLAINT

What is your primary reason for being evaluated?

What happened? (How did you get your injury or illness)

Date of onset of illness:

HISTORY OF PRESENT ILLNESS

Location (site(s) of problem):

Quality (sharp, dull, throbbing, etc):

Severity (minor, moderate, severe):

Duration (intermittent, constant, minutes,etc.)

Timing (with exercise, nightly, after meals, etc):

Context (worsening, recurrent, etc):

Modifying Factors (rest, heat, cold, limb elevation):

Associated signs and symptoms (bruising, numbness, tingling, etc):

What treatments have you had for this problem? (Physicians, procedures, Physical Therapy, Chiropractic, etc)

Which of these has helped?

Have you had any diagnostic studies? (X-rays, CT scans, MRI scans, Lab work, or EMG's)

Do you have any secondary complaints?

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PAST MEDICAL AND SOCIAL HISTORY

Do you have any problems with:
Heart disease Lung disease Kidney disease Liver disease High Blood Pressure Diabetes
Arthritis Depression Scoliosis Osteoporosis Cancer OB/GYN Other:

Do you see a doctor or take medication for any other problem?

Have you had any previous injuries? (Motor vehicle accidents, falls, work related injuries or other accidents of significance)

Which town do you live in?	What is your living situation? Rent Own Home	Marital Status: Single Married Divorced Separated Widowed	How many children do you have?

What is your family medical history? What medical problems do your parents or siblings have? Please list relationship and problem: (example, mother-diabetes)

Do you have any new family stress or change in family structure?

SURGICAL HISTORY

Surgical Procedure & Date
Tonsils ____ Appendix_____ Gall Bladder_____ Hear_____ Head & Neck_____
Neck & Spine_____ OB/GYN_____ Joint(Shoulder, elbow, wrist, Carpal Tunnel, hip, knee ankle) _____
Other:

MEDICAL HISTORY

Are you allergic to any medications? Yes No	Which medication are you allergic to?

Please list your current medications:

Do you use Alcohol? Yes No	Do you use Tobacco? Yes No	Is there anything else you are taking? (Herbs, Recreational Drugs, None)

REVIEW OF SYSTEMS

Do you have any problems in the following areas:
General Exercise Daily Activities Bowels Bladder Nutrition Swallow Eyes Skin
Ears, nose, mouth, throat Walking Numbness Weakness Sleep Pain Respiratory
Psychiatric Cardiovascular Endocrine Blood disorders Allergies Neurologic Muscle/Joints
Weight Loss/Weight Gain_____

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Is there anything else you would like to talk to the doctor about?

PAIN CHART

Patient Name:_____ Date:_____

PAIN DRAWING: Use the symbols below to mark the areas on your body where you feel the following sensations. Include ALL affected areas.				
BURNING **X**	NUMBNESS **O**	PINS & NEEDLES =	STABBING /	ACHE ^

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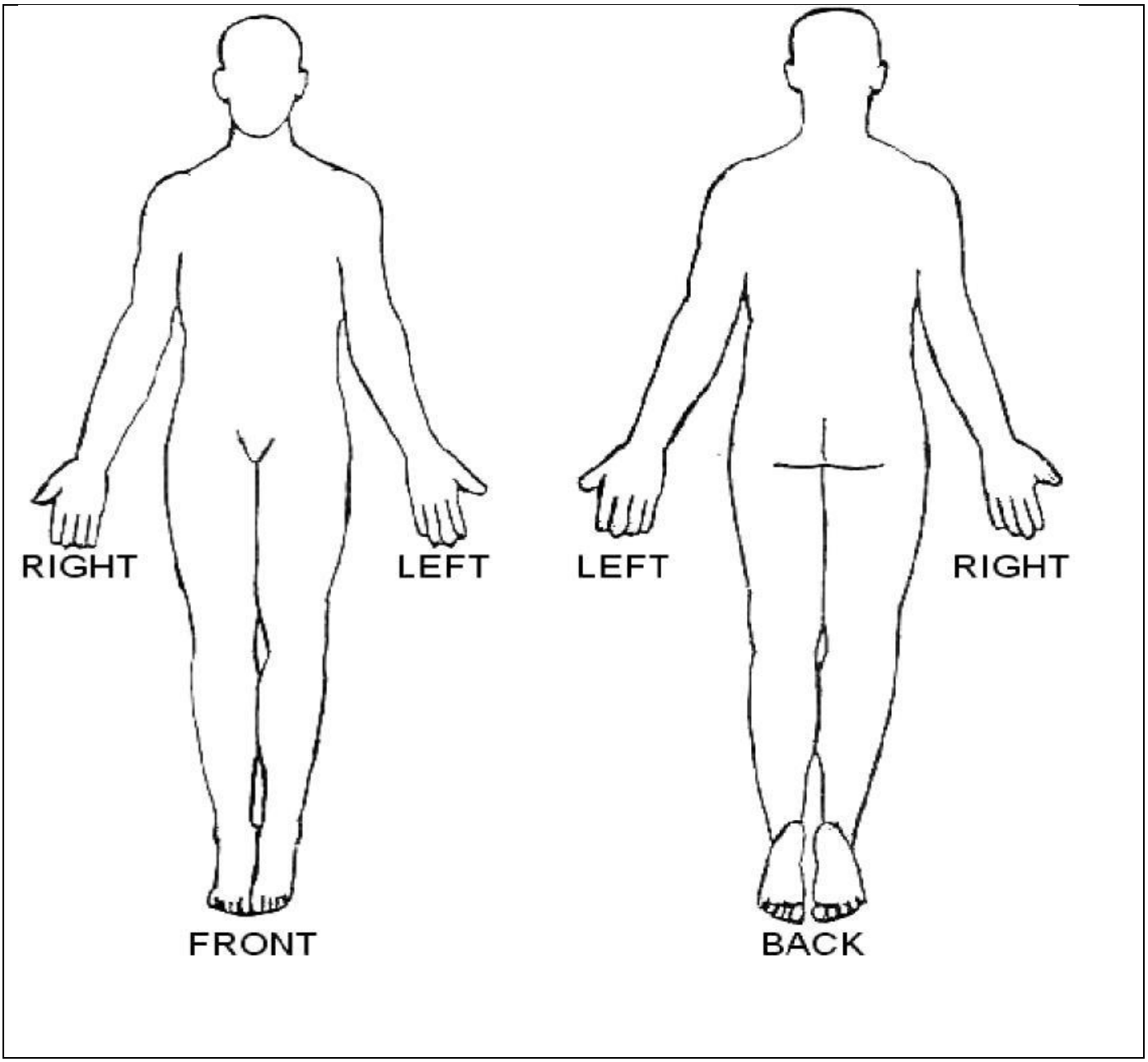

Please answer the questions below in regards to your symptoms that we are treating you for.

Explanations for the below abbreviations

NSAIDS: Non steroid medications, over the counter medications

Opiates: examples: Vicoden, Norco, Percocet

Anticonvulsants: Lyrica, Neurontin

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PT: Physical Therapy

PREVIOUS THERAPIES

	Primary complaint	**Secondary complaint**
	_____	_____
NSAIDS	Yes No Date:	Yes No Date:
Opiates	Yes No Date:	Yes No Date:
Anticonvulsants	Yes No Date:	Yes No Date:
Acupuncture	Yes No Date:	Yes No Date:
PT	Yes No Date:	Yes No Date:
Chiropractic	Yes No Date:	Yes No Date:
Injections	Yes No Date:	Yes No Date:
Surgery	Yes No Date:	Yes No Date:
Implants	Yes No Date:	Yes No Date:
XRAYS/MRIS	Yes No Date:	Yes No Date: