Patient Intake & History (PVT)

Today's Date: _____

Patient Name: _____ **Sex** □ **M** □ **F** **Age:** _____

Date of Birth: _____ **SSN:** _____

Home Phone#: _____ **Cell#:** _____ **Work#:**_____

Home Address: _____

□ **Married** □ **Widowed** □ **Single** □ **Separated** □ **Divorced** □ **Minor**

Spouse's Name: _____ **Spouse Cell Phone#** _____

IN CASE OF AN EMERGENCY, CONTACT

Name: _____ **Relationship:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Work Phone: ( ) _____

Employer Name: _____ **Phone#** _____

QUESTIONNAIRE

1. Describe reason for your visit and date of onset:

_____

_____

_____

_____

2. Have you seen any other doctors or gone to any other clinics after the injury? □ Yes □ No

If yes, when did you go? _____

Doctor/Clinic name and Telephone #: _____

_____

What treatment did you receive: _____

3. Have you had any diagnostic studies performed since your injury? ☐ Yes ☐ No

If yes, what type of study and what body parts?

☐ X-Rays: _____

☐ MRI: _____

☐ CT Scans: _____

☐ EMG/NCV Test: _____

☐ Other: _____

4. Have you had any previous problems with the current injured body parts? ☐ Yes ☐ No

If yes, explain:_____

5. Automobile Accidents:

Have you had any prior motor vehicle accidents? ☐ Yes ☐ No

If yes, explain: _____

_____

6. Industrial Injuries:

Have you had any industrial related injuries? ☐ Yes ☐ No

If yes, explain: _____

_____

7. Any other Injuries:

Have you had any industrial related injuries? ☐ Yes ☐ No

If yes, explain: _____

_____

8. Height & Weight:

What is your height? _____ feet _____ inches What is your weight? _____ lbs.

Dominant hand? □ Right □ Left

9. Are you pregnant? □ Yes □ No

If yes, how many months? _____

10. Are you currently working? □ Yes □ No Your Occupation: _____

If you are currently not working when was the last day that you worked? _____

If you are currently not working are you on disability? □ Yes □ No

11. Patient's Complaints:

Do you have any pain? □ Yes □ No

What body part(s)? □ Headaches □ Neck □ Mid back □ Low back

□ Shoulder R / L □ Elbow R / L □ Wrist R / L □ Hand R / L □ Hip R / L

□ Knee R / L □ Ankle R / L □ Foot R / L □ Chest Pain

Rate the intensity of your pain today next to body part affected, use scale below.

No Pain Most Pain

0 1 2 3 4 5 6 7 8 9 10

Mild Symptoms Moderate Symptoms Severe

What does the pain feel like? □ Dull □ Sharp □ Burning □ Throbbing □ No Pain

□ Numbness and tingling sensation at: _____

□ Radiating pain from _____ to _____

How often do you feel the pain? □ Rare □ Occasional □ Intermittent □ Constant

Activity or position that makes the pain worse? □ Movement □ Lifting □ Bending

Activity or position that makes the pain less? ☐ Ice ☐ Medication ☐ Therapy ☐ Rest

Is there any stiffness? ☐ Yes ☐ No Where is it? _____

Is there any weakness? ☐ Yes ☐ No Where is it? _____

Is there any swelling? ☐ Yes ☐ No Where is it? _____

Is there any grinding? ☐ Yes ☐ No Where is it? _____

Is there any locking? ☐ Yes ☐ No Where is it? _____

Is there any giving way? ☐ Yes ☐ No Where is it? _____

Do you have any deformity/scar? ☐ Yes ☐ No Where is it? _____

_____ _____ _____

Patient's signature Date Interpreter's name (if applicable)

Patient Name: _____

DOB: _____

Medical History:

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrhythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type _____			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis – TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER:		

Please list any **operations/surgeries** you have had:

SURGERY/ REASON	YEAR	**SURGERY/REASON**	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **Medications** that you are currently taking:

MEDICATION	DOSE	DOCTOR	**MEDICATION**	DOSE	DOCTOR
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you have any **allergies** to medications/substances/latex? Yes No

_____

Patient Name: _____

DOB: _____

Family Medical History: Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Social History:

Alcohol use: Yes No Drinks per week: _____

Cigarette/Tobacco use: Yes No Packs per day: _____ Years: _____

Illicit Drug use: Yes No Type: _____

Review of Symptoms: Please mark any of the symptoms that apply to you:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

X _____ Date: _____

PARSA ORTHOPEDICS
ORTHOPEDIC SURGERY & SPORTS MEDICINE

Patient Name:
Date of Service:
DOI:
Referral:
Physician:
Location:

ASSIGNMENT OF BENEFITS

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Dr. Ronna Parsa
1200 Rosecrans Boulevard, Suite 110
Manhattan Beach, CA 90266

for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, Dr. Ronna Parsa will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

Actual Plan benefits can not be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

X _____

Patient Signature or Responsible Person Date

_____

Relationship to patient if not patient

PARSA ORTHOPEDICS

ORTHOPEDIC SURGERY & SPORTS MEDICINE

Patient Name:
Date of Service:
DOI:
Employer:
Insurance:
Referal:
D.O.B.:

PATIENT AUTHORIZATION

CONSENT FOR EVALUATION AND TREATMENT

I hereby authorize Dr. Ronna Parsa and/or its affiliates, their physicians, employees or agents together with any laboratory designated by Dr. Ronna Parsa or any of its affiliates to perform a physical examination and/ or any medical treatment deemed necessary by the treating physicians. This includes, but is not limited to, any required medical examinations, x-rays, medical procedures and medical, diagnostic or laboratory tests ordered by the center physician(s) to be carried out by the designated center staff.

RELEASE OF INFORMATION

I hereby authorize Dr. Ronna Parsa and/or its affiliates to disclose to my employer, insurance company and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. I authorize the center to release any appropriate information concerning my medical history, examinations, treatments, or other diagnostic procedures, including copies of my records to official requesters, including but not limited to insurance companies, third party administrators, or utilization review organizations, healthcare service plans, or any other person or entity as necessary in connection with certification, payment or reimbursement for services rendered. I acknowledge that such information may be released pursuant to the following paragraph.

CONFIDENTIALITY

It is the policy of Dr. Ronna Parsa and its affiliates to protect all medical records against loss, tampering, destruction and access by unauthorized persons. I understand that medical records may be periodically reviewed by national accreditation or certification surveyors, and other necessary quality assurance personnel and I authorize such release of information. I acknowledge that my records and associated documentation may be disclosed to third-parties, including government agencies, as required by law, including, but not limited to, pursuant to a warrant, subpoena or other court order, and I hereby agree not to pursue and action against Dr. Ronna Parsa, its physicians or affiliates for any damages I may suffer as a result of such disclosure.

X _____

Patient Signature Date

_____

Parent / Guardian Name