

Pacific Pain Physicians
 R. Michael Hullander, M.D. Ralph Mozingo, D.O, Mark Ashtiani-Jamali, P.A.
 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 <input type="radio"/> Male <input type="radio"/> Female | | Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes type: <input type="checkbox"/> Auto <input type="checkbox"/> Industrial <input type="checkbox"/> Other Date of accident: _____ Accident in what state: _____ Is the accident employment related? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| REFERRED BY: | | YOUR EMPLOYMENT STATUS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Other | | If you are a student: <input type="checkbox"/> Full time <input type="checkbox"/> 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: _____

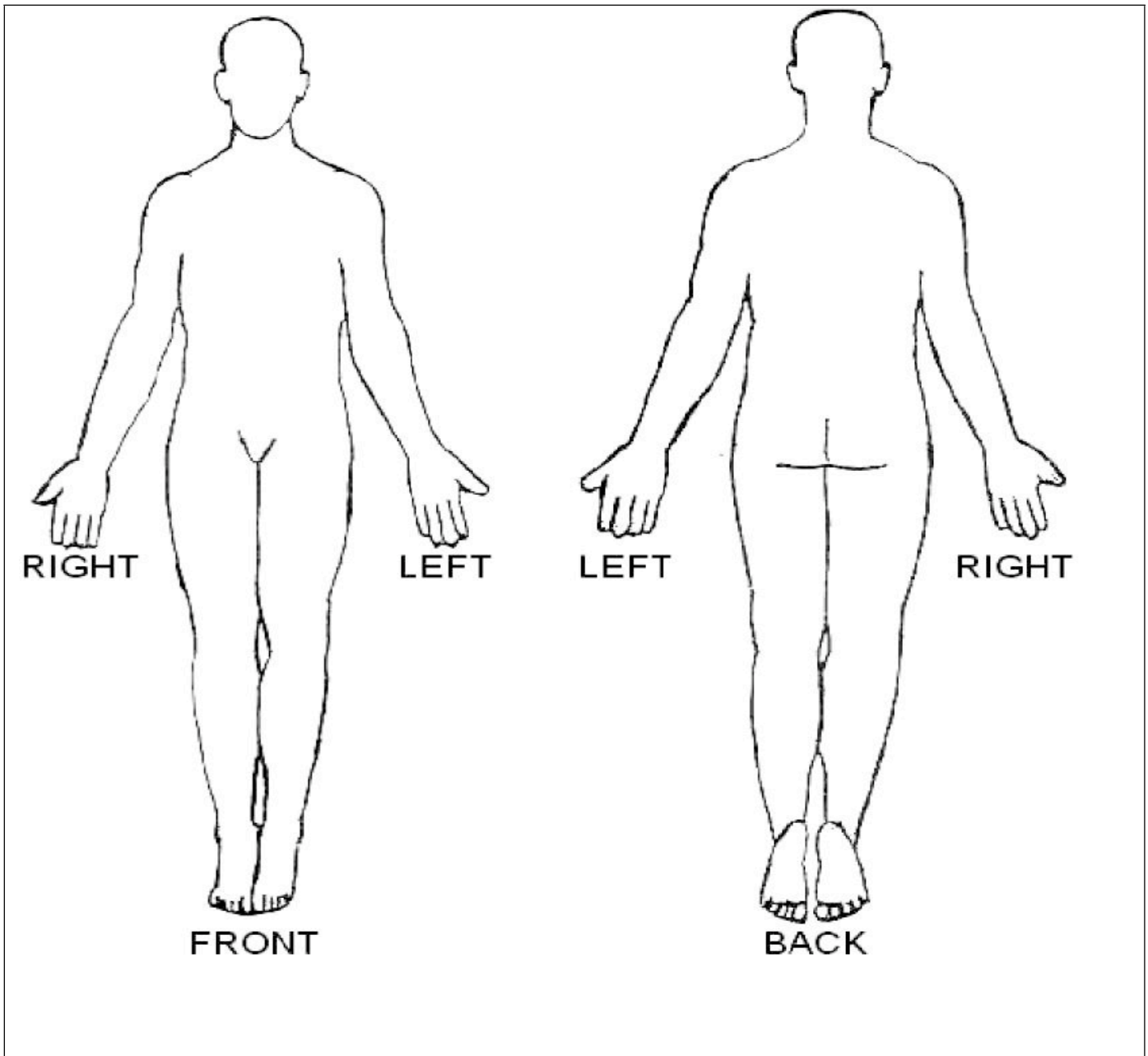
PAIN DRAWING: Use the symbols below to mark the areas on your body where you feel the following sensations. Include ALL affected areas.

| | | | | |
|---------------------|----------------------|----------------------------|----------------------|------------------|
| 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

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: |