NAPA VALLEY ORTHOPAEDIC
MEDICAL GROUP, INC.
3273 CLAREMONT WAY, SUITE 100, NAPA, CA 94558 | main: 707.254.7117 | fax: 707.265.6435

PATIENT INFORMATION

Patient
Name/Nombre_____

Birth date/Fecha de
Nacimeinto_____Age/Edad_____Sex/Sexo_____

How do you prefer to be addressed by our physicians and staff?
Como prefiere que le llamen los doctores y las personas de la oficina?

_____

Address/ Domicilio

_____

City, State, Zip/ Ciudad, Estado, Zona Postal

_____

Home Phone/ Numero de Telephono _____

Cell Phone/ Numero de Cellular _____

Social Security #/Numero de Seguro Social _____

Drivers License #/ Licencia de Manejar _____

Marital Status/ Estado Civil_____

Employer/
Nombre del Empleador _____

WorkPhone/ Numero de Trabajar _____

NAPA VALLEY ORTHOPAEDIC
MEDICAL GROUP, INC.

Work Address/ Domicilio del Empleador

_____

City, State, Zip/ Ciudad, Estado, Zona Postal _____

Occupation/ Ocupacion _____

Nature of Business/ Tipo de Negocio _____

Referred by/ Referido por_____

Is this your Primary Care Doctor/ Es este to Doctor Primario _____

If no, Name of Primary Care Doctor/Si no, Nombre del Doctor Primario

._____

Emergency Contact/ Contacto de Emergencia

Name/Phone_____
Nombre/Telefone

May we leave a message at your home?
With a person____ On answering machine___
Podemos dejar mensaje en su casa?
Con una persona___ En la maquina de mensajes___

May we leave a message at your work? With a person? ____On voicemail?____
Podemoso dejar mensaje en su trabajo?
Con una persona? ___En el correo de voz? ___

Is this visit related to a Work Injury_____ If yes, Date of Injury_____
Es esta visita relacionada con lesion de trabajo_____
Si si, fecha de lesion_____

NAPA VALLEY ORTHOPAEDIC MEDICAL GROUP, INC.

Is this visit related to an accident?_____Is this visit related to an injury?_____
Es esta visita relacionada con accidente? _____
Es esta visita relacionada con lesion? _____

If yes, Date of Accident or Injury_____
Si si, Fecha de Accidente o Lesion _____

Briefly describe circumstances_____
Brevemente describa la circunstancia

Responsible Party if other that Patient:
Persona Responsable si otra del paciente:

Name_____Rel to Patient_____
Nombre Relacion al Paciente

Address_____
Domicilio

City, State, Zip_____
Ciudad, Estado, Zona Postal

Phone_____Work Phone_____
Numero de Telefono Telefono del Empleador

Employer_____Occupation_____
Nombre del Empleador Ocupacion

NAPA VALLEY ORTHOPAEDIC MEDICAL GROUP, INC.

Workers Comp Insurance Information:

Employer Name _____
Nombre del Empleador

Address: _____
Domicilio del empleador

City, State, Zip_____
Ciudad, Estado, ZonaPostal

Contact Person_____Phone_____
Persona del Contacto Numero de Telefono

Date of Injury_____Time of Injury_____
Fecha de Lecion Tiempo de Lecion

Description of Accident_____
Explicar el Accidente

Work Comp Insurance
Carrier:_____
Portador del seguro de work comp

Claim Adjuster Name:_____
Nombre del Ajustador

Claim Adjuster
Phone:_____
Telefono del Ajustador

Claim
Number_____
Numero de reclamo
Do you have an attorney?_____
Tiene un abogado?

Name of
Attorney_____
Nombre del Abogado

NAPA VALLEY ORTHOPAEDIC
MEDICAL GROUP, INC.

Address_____
Domicilio

City, State, Zip_____
Ciudad, Estado, Zona Postal

Phone_____Fax_____
Telefono Fax

Napa Valley Orthopaedic Medical Group, Inc.

CONSENT FOR TREATMENT

Adult

I hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

OR

Complete for a Minor

I certify that I am a legal guardian of _____, a minor, and I do hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

INSURANCE ASSIGNMENT

I give permission to Napa Valley Orthopaedic Medical Group, Inc. to bill my insurance carrier for services rendered. I understand that this is a service provided by Napa Valley Orthopaedic Medical Group, Inc. I request that payment of authorized Medicare or other insurance company benefits be made directly to Napa Valley Orthopaedic Medical Group, Inc., otherwise payable to me, for any services furnished to me by Napa Valley Orthopaedic Medical Group, Inc. Regulations pertaining to Medicare assignment of benefits apply.

I permit a copy of this authorization to be used in place of the original. I understand that I must inform my physician if I know that a party other than Medicare is responsible for paying for my treatment.

I understand that I am responsible for my medical bills unless I have verified coverage under an active Worker's Compensation claim. I hereby guarantee payment of all physician/provider charges and understand that any amount not paid by insurance within 60 days of service becomes my personal responsibility unless my injury is covered under an active Worker's Compensation claim. Examples of this would include but not be limited to any coinsurance, deductibles, and copayments.

INFORMATION RELEASE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance, information needed for this or a related Medicare or other insurance company claim. I understand that my signature requests that payment be made and authorizes release of any medical or other information necessary to pay the claim.

PAYMENT POLICY

It has been explained to me that if I am paying privately for medical treatment, payment of all charges is to be made in full at the time of service unless previous arrangements have been made, and I agree to pay all the charges.

If there is a co-payment for the medical service, I understand that it is due at the time of service, and I agree to make this payment.

I have carefully read and agree to the above information.

Signature: _____ ***Date:*** _____

NAPA VALLEY ORTHOPAEDIC MEDICAL GROUP, INC.

HEALTH INSURANCE PORTABILTY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy (5 pages) of the Napa Valley Orthopaedic Medical Group, Inc. Notice of Privacy Practices. This Notice describes how Napa Valley Orthopaedic Medical Group, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

Name: _____

Signature: _____

Date: _____

I have been given an opportunity to take a copy of the Napa Valley Orthopaedic Medical Group, Inc. Notice of Privacy Practices to review and hereby voluntarily decline to take a copy for my own review. I have been made aware that Napa Valley Orthopaedic Medical Group, Inc. functions under the guidelines of the Health Insurance Portability and Accountability Act (HIPAA), but do not wish a hard copy of the policy at this time.

Name: _____

Signature: _____

Date: _____

New Work Comp Spine Patient Information Form

Welcome to the Napa Valley Orthopaedic Medical Group, Inc.

Please take some time filling out these forms to assist us in gathering information about your spine injury and work situation. If you require more space please make a note of it and we will discuss it in more detail during your visit.

Please answer all questions. If a question does not apply please put an X in the box. If you do not know the answer the please put a ? in the box.

Name:_____

General Questions:

What is your date of birth?	
What is your Social Security Number?	
What is your complete mailing address?	
What is your phone number?	
What was the date of your injury?	
Who was your employer at the time of your injury?	
What is your employer's address?	
Are you represented by a lawyer? If so what is your lawyer's name and adress?	
How tall are you?	
How much do you weight?	
Are you right or left handed?	Right ☐ Left ☐ Both ☐

History of the Injury:

Please briefly describe how your injury occurred	
After your injury did you have pain immeadiatly or did it come on gradually?	
Did your pain get worse over the next hours or days?	
Did you report your injury on the date of injury? If not when did you report it?	
What is the name of the person you reported the injury to?	

History of Treatment:

Where were you first treated for this injury?	
What medications were you prescribed?	
Did you receive physical therapy? Where and how many visits? Did it help?	
Were you taken off work?	
Were you returned to work with modifications? If so what?	
Have you had X-rays or an MRI? If so, when were they done and where?	
Were you refered to any other doctor for treatment?	
What other treatments have you had?	
What other treatments have been recomended?	
Have you had surgery for this injury? If so what surgery have you had and did it help?	
Overall have the treatments you have received helped you?	

History of Other Injuries:

Prior to this injury did you have any other work related injuries to this part of your body?	
If yes, please describe the injury. Did you still have symptoms when this injury occurred?	
Since your injury have you re-injured this part of your body?	
Have you ever received a disability award for any work related injury?	
Have you had any other major accidents or injuries? If so please describe.	

Current Symptoms:

What part of your body is currently bothering you?	
How often does this problem bother you? (every day, once a week, several times a year…)	
When this problem is bothering you is it constant or does it come and go?	
From 1-10 rate your pain:	1 2 3 4 5 6 7 8 9 10
Describe your pain eg sharp, burning, achy, deep, dull:	
Does your pain radiate to another part of your body? If so where?	
What makes your symptoms better?	
What makes your symptoms worse?	
Do your symptoms disturb your sleep? How?	
What time of the day are your symptoms the worst?	
What medications are you taking for this problem? Do they help?	
Do you feel that in the future this problem will get better, stay the same or become worse?	
What do you think you need in order to get better?	

Job History:

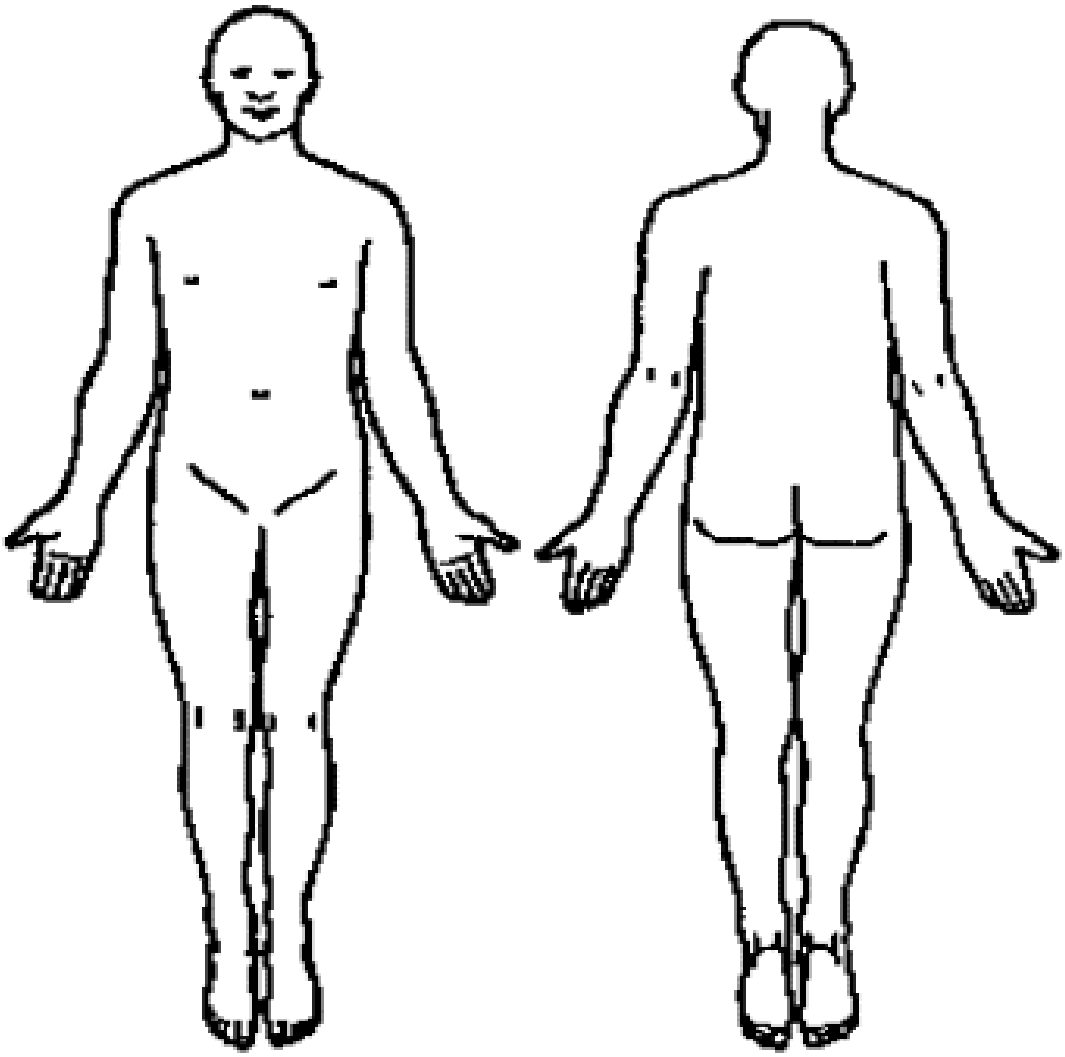
At the time of injury who was you employer?	
When did you start working for this employer?	
Before you started this job what other jobs had you done?	
Did you have any other jobs or employers at the time of injury?	
Are you still working for this employer?	
If you are not still working for this employer, why?	
Have you obtained a new job with a different employer?	

Job Description:

What was your job title?	
What were you job duties?	
How many hours a day did you work?	
How many days a week did you work?	
What was the maxium ammount of weight you were required to lift on this job?	

Pain Diagram

On the diagram please draw where your symptoms are:



Medical History:

Please list any **medical problems** that you have, even if they are under control.

Please list any **surgeries** you have had.

Please list any **allergies** you have to medications or other significant allergies.

Please list your current **medications** (if you have a list, bring it to the receptionist to copy)

Please List your pharmacy name and number	

Please list any major medical problems that run in you **family**.

Relative	**Disorder/Disease**	**Disorder/Disease**
Mother		
Father		
Brothers/Sisters		
Other Family Members		

Social History:

Do you smoke?	
How many packs a day?	
How long have you smoked?	
Do you use other tobacco products?	
Do you drink alcohol?	
How many drinks do you have a day?	
Do you use any other drugs?	
What is your marital status:	
How many year of school have you completed?	
Do you exercise?	
What are your hobbies?	

Review of Systems:

Do you have any of the following symptoms?

Category	**Symptom**	**Yes**	**No**
General	Fever	☐	☐
	Chills	☐	☐
	Recent weight loss	☐	☐
	Recent weight gain	☐	☐
	history of cancer	☐	☐
Eyes	Glasses	☐	☐
	Double Vision	☐	☐
	Blurry Vision	☐	☐
	Recent Changes in Vision	☐	☐
ENT	Hearing Loss	☐	☐
	Difficulty Swallowing	☐	☐
	Change in Voice	☐	☐
	Sinus Infections	☐	☐
Respiratory	Asthma	☐	☐
	Emphysema	☐	☐
	Shortness of Breath	☐	☐
GI	Acid Reflux	☐	☐
	Stomach Pain	☐	☐
	Stomach Ulcers	☐	☐
	GI Bleeding	☐	☐
	Liver Problems	☐	☐
	Hepatitis	☐	☐
GU	Bladder Infections	☐	☐
	Difficulty Urinating	☐	☐

	Loss of Urinary Continence	☐	☐

Category	**Symptom**	**Yes**	**No**
Musculoskeletal	Joint Pain	☐	☐
	Joint Swelling	☐	☐
	Weakness	☐	☐
Skin	Rashes	☐	☐
	Recent Cuts	☐	☐
Neurologic	Loss of Balance	☐	☐
	Loss of Coordination	☐	☐
	Numbness	☐	☐
	Weakness	☐	☐
	Strokes	☐	☐
	Seizure	☐	☐
Psychiatric	Depression	☐	☐
	Anxiety	☐	☐
Hematological	Blood Clots	☐	☐
	Bleeding Problems	☐	☐
	Immune Disorder	☐	☐
	HIV/AIDS	☐	☐
Endocrine	Diabetes	☐	☐

Has your injury interfered with or cause problems for you in any of the following activities:

1. Self-care, Teeth, Personal Hygiene.	
2. Communication	
3. Physical Activity	
4. Sensory Function	
5. Non-Specialized Hand Activities	
6. Travel	
7. Sexual Function	
8. Sleep	

Thank you for taking the time to fill out this form.