PERSONAL INJURY
PATIENT INFORMATION

NAME:
(LAST)_____ **(FIRST)**_____**(INITIAL)**_____

STREET ADDRESS:_____**APT.**_____

CITY_____ **STATE**_____ **ZIP**_____

PHONE (_____) _____ **SOCIAL SECURITY #** _____

BIRTHDATE_____ **AGE**_____ **SEX:** ☐ **MALE** ☐ **FEMALE** **MARRIED:** ☐ **YES** ☐ **NO**

DRIVER LICENSE NUMBER _____

WORK PHONE (_____) _____ **PRIMARY HAND:** ☐**RIGHT** ☐**LEFT**

INSURANCE INFORMATION

NAME OF *YOUR* AUTO INSURANCE COMPANY:_____

ADDRESS: _____ **STATE**_____ **ZIP** _____

POLICY NUMBER_____ **MED-PAY COVERAGE?** ☐**YES** ☐**NO**

NAME OF INSURANCE AGENT_____ **PHONE (_____)**_____

NAME OF *YOUR* PRIVATE MEDICAL INSURACE_____

ADDRESS:_____ **STATE**_____ **ZIP**_____

NAME OF INSURED: _____

YOUR RELATIONSHIP TO INSURED: _____

POLICY NUMBER _____ **GROUP NUMBER** _____

IF EMPLOYER INSURANCE, EMPLOYER _____

NAME OF ADDITIONAL PRIVATE MEDICAL INSURANCE: _____

ADDRESS: _____ **STATE** _____ **ZIP** _____

NAME OF INSURED _____ **YOUR RELATIONSHIP TO INSURED** _____

POLICY NUMBER _____ **GROUP NUMBER** _____

IF EMPLOYER INSURANCE, EMPLOYER _____

THE FOLLOWING INFORMATION CONCERNS YOUR GENERAL HEALTH AND BACKGROUND. ALTHOUGH SOME OF THE QUESTIONS MAY NOT APPEAR TO APPLY TO YOUR PRESENT INJURY, THE INFORMATION MAY HELP THE DOCTOR TO DIAGNOSE YOUR CONDITION. PLEASE FILL OUT THE FORM AS COMPLETEL AS POSSIBLE. NOTIFY OUR STAFF IF YOU HAVE ANY QUESTIONS! THEY WILL BE GLAD TO HELP YOU.

INJURY INFORMATION

DATE OF INJURY _____ **TIME OF INJURY** _____

IF YOU HAD MORE THAN ONE INJURY, PLEASE LIST: _____

_____

_____

PRIOR TO THE DATE(S) ABOVE, HAD YOU EVER INJURED THE SAME AREA OF OUR BODY? _____

_____

BRIEFLY DESCRIBE HOW THE INJURY HAPPENED: (DID YOU FALL, WERE YOU STRUCK BY SOMETHING, WERE YOU IN AN AUTO ACCIDENT, WERE YOU USING ANY SPECIAL EQUIPMENT, ETC.) ***PERTAINS TO PRESENT INJURY***

_____

_____

_____

DESCRIBE WHAT HAPPENED TO YOU IN THE ACCIDENT (THROWN AROUND, STRUCK SOMETHING, LANDED ON YOUR ARM, ETC.)

_____

_____

_____

WHAT TYPE OF PAIN OR DISCOMFORT DID YOU EXPERIENCE AT THE TIME OF THE INJURY?

_____

_____

WHAT TYPE OF PAIN DID YOU LATER EXPERIENCE, AND, APPROXIMATELY WHEN:

_____

_____

WHAT ARE YOUR CURRENT COMPLAINTS:

1) _____

2) _____

3) _____

4) _____

WHAT MAKES THE PAIN FEEL BETTER? _____

WHAT MAKES THE PAIN FEEL WORSE? _____

MEDICAL TREATMENT

WHAT OCCURRED IMMEDIATELY AFTER THE INCIDENT? (DID YOU NOTIFY THE POLICE, WERE YOU PROVIDED WITH MEDICAL TREATMENT, ETC.)

_____

_____

_____

DID YOU GO TO A HOSPITAL? ☐ **YES** ☐ **NO** **IF SO, NAME OF HOSPITAL** _____

_____

IF YOU DO NOT SEEK OR RECEIVE MEDICAL TREATMENT IMMEDIATELY FOLLOWING THE INCIDENT, WHEN, AND FOR WHAT REASON DID YOU SEEK OR RECEIVE MEDICAL CARE?

_____

_____

_____

FOLLOWING YOUR FIRST MEDICAL CARE, DID YOU SEE ANY OTHER DOCTOR/S OR UNDERGO ANY SPECIAL TESTS? IF SO, PLEASE LIST THE DOCTOR OR FACILITY VISITED, AND BRIEFLY STATE WHY YOU SAW THEM (REFERRED BY SOMEONE ELSE OR DUE TO PAIN AND DISCOMFORT, ETC.), WHAT THEY TOLD YOU YOUR PROBLEM WAS, AND WHAT THEY DID FOR YOU.

_____

_____

_____

_____

CURRENT STATUS

WHAT IS YOUR CURRENT STATUS? (ARE YOU UNDER A DOCTOR'S CARE, ARE YOU RECEIVING TREATMENTS, DO YOU HAVE ANY FURTURE APPOINTMENTS WITH OTHER DOCTORS FOR THIS CONDITION)

_____

_____

ARE YOU CURRENTLY WORKING? _____ **FULL DUTY?**_____

IF NOT WORKING FULL DUTY, PLEASE DESCRIBE YOUR LIMITATIONS:

_____

WHAT IS YOUR JOB? _____

DESCRIBE ACTIVITY AT WORK (LIFTING, SITTING, BENDING, ETC.)

_____

_____

PAST MEDICAL HISTORY

PERSONAL DOCTOR: _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

TELEPHONE: (_____) _____

APPROXIMATE DATE OF LAST VISIT _____

DO YOU HAVE, OR HAVE YOU HAD IN THE PAST, ANY OF THE FOLLOWING? (CIRCLE)

ALCOHOLISM	Y	N	GOUT	Y	N
ANEMIA	Y	N	HEART TROUBLE	Y	N
ARTHRITIS	Y	N	HIGH BLOOD PRESSURE	Y	N
EDEMA (SWELLING)	Y	N	KIDNEY DISEASE	Y	N
BLEEDING DISORDER	Y	N	LIVER DISEASE	Y	N
CANCER	Y	N	MENTAL ILLNESS	Y	N
DIABETES	Y	N	MIGRAINE HEADACHES	Y	N
EMPHYSEMA	Y	N	STOMACH ULCERS	Y	N
EPILEPSY	Y	N	STROKE	Y	N
GLAUCOMA	Y	N	TUBERCULOSIS	Y	N
BREATHING DISORDER	Y	N	DRUG ADDICTION	Y	N

OTHER SERIOUS DISEASES: _____

SERIOUS BURNS (DESCRIBE): _____

WHEN? _____

WOUNDS (DESCRIBE): _____

WHEN? _____

SURGERIES

APPENDIX_____ WHEN_____
GALL BLADDER_____ WHEN_____
HERNIA_____ WHEN_____
HYSTERECTOMY _____ WHEN_____
STOMACH _____ WHEN_____
TONSILS _____ WHEN_____

OTHER SURGERIES: _____

HAVE YOU BEEN HOSPITALIZED FOR ANY OTHER PROBLEMS? PLEASE LIST:

_____

HAVE YOU HAD ANY OTHER ACCIDENTS, INCLUDING AUTO ACCIDENTS, SERIOUS BURNS, MAJOR CUTS, BROKEN BONES, OR OTHER INJURIES? PLEASE LIST:

_____

_____

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF SO, PLEASE LIST:

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST:

_____

FAMILY HISTORY

FATHER: AGE _____ HEALTH _____

MOTHER: AGE _____ HEALTH _____

DO ANY BROTHERS OR SISTERS HAVE HEALTH PROBLEMS? PLEASE LIST:

_____

_____

PERSONAL AND SOCIAL HISTORY

HEIGHT _____ WEIGHT _____ ☐ RIGHT / ☐ LEFT HANDED?

DO YOU SMOKE? ☐ YES ☐ NO IF SO, HOW MUCH? _____ SINCE? _____

DO YOUR DRINK? ☐ YES ☐ NO IF SO, HOW MUCH? _____ SINCE? _____

ATTORNEY'S NAME: _____

ADDRESS: _____ STATE _____ ZIP _____

PHONE: (_____) _____

SIGNATURE _____ DATE _____

PACIFICA ORTHOPEDICS & SPORTS MEDICINE CENTER
18800 DELWAREA ST. STE # 1100
HUNTINGTON BEACH, CA 92648
(714)841-5333 FAX: (714)841-5303

CONSENT FOR MEDICAL TREATMENT

I HEREBY CONSENT TO AND AUTHORIZE THE ADMINISTRATION OF ALL REATMENTS THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGEMENT OF THE PHYSICIAN, AND I AUTHORIZE THIS MEDICAL CLINIC AND THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS OF THIS TREATMENT.

PATIENT: _____ DATE: _____

OTHER PERSON RESPONSIBLE: _____
(RELATIONSHIP)

WITNESS: _____