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PATIENT DEMOGRAPHIC/REFERRAL SHEET

Date: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____ ☐ Female ☐ Male

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Primary Language: _____

E-Mail: _____ Best way to contact: _____

Other Contact: _____ Relationship: _____ Phone: _____

Employer at time of Injury: _____ Work Phone: _____

Occupation at time of Injury : _____ **DOI:** _____

Body Part (s) Injured: _____

APPLICANT ATTORNEY INFORMATION

Name: _____

Contact Person: _____

Address: _____

_____

Phone: _____

Fax: _____

REFERRAL SOURCE

Name: _____

Contact Person: _____

Address: _____

_____

Phone: _____

Fax: _____

INSURANCE COMPANY INFORMATION

Insurance Company: _____

Claim #: _____

Address: _____

_____

Adjuster: _____

Phone : _____

Fax: _____

Nurse Case Manager: _____

Phone : _____

Fax: _____

Medication Card: ☐ YES ☐ NO

Interpreter Required: ☐ YES ☐ NO

Company _____

Phone : _____

PLEASE READ OTHER SIDE AND SIGN. THANK YOU.

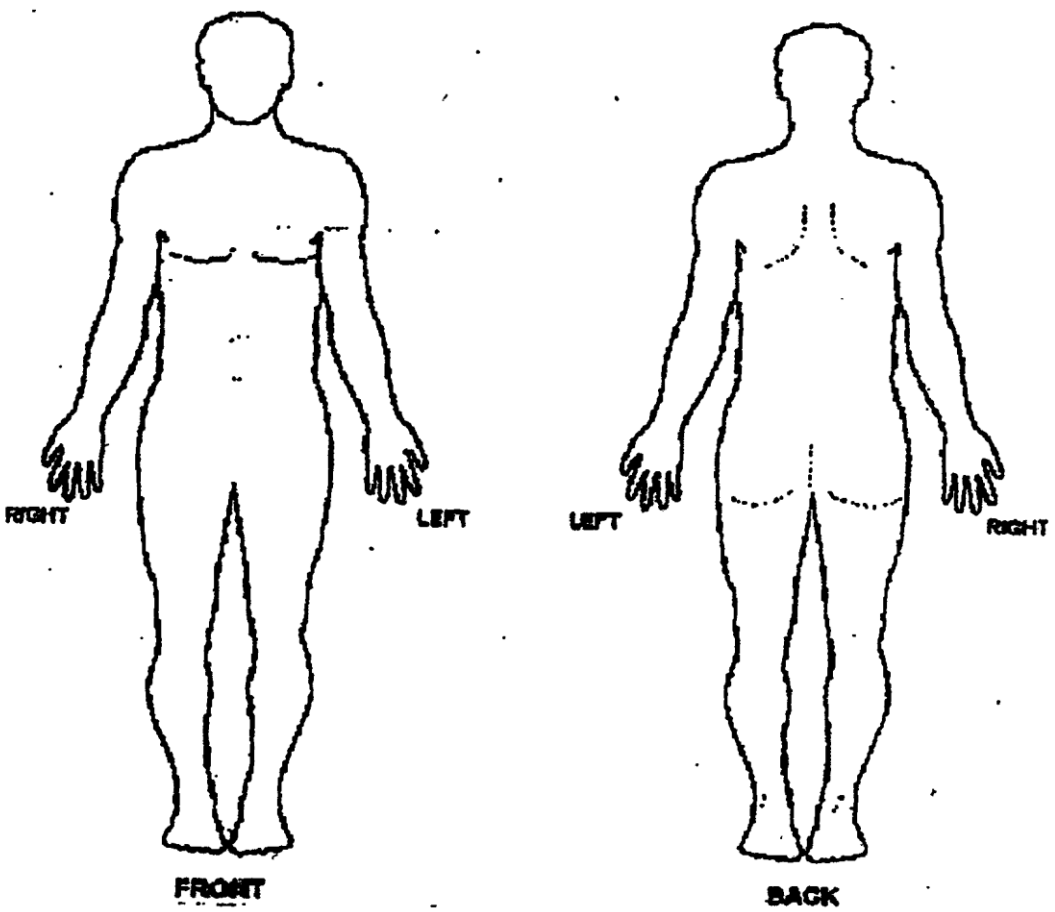
Name:_____ Age: _____ Sex: M F

Handedness: R L Date of Injury: _____ Height: _____ Weight:_____

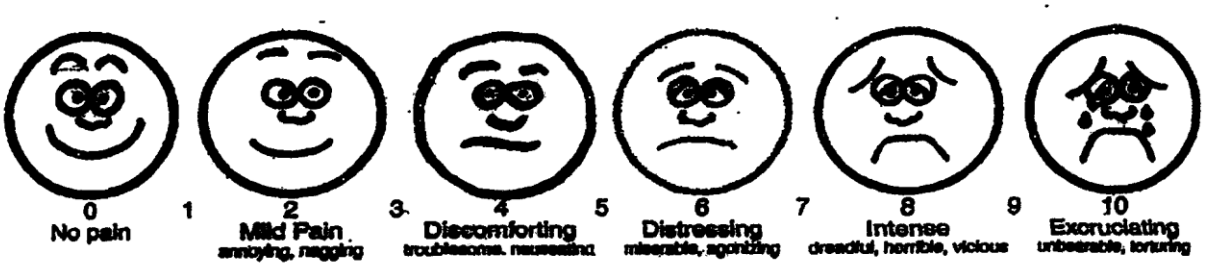
PAIN DIAGRAM

MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS

PAIN	NUMBNESS	STIFNESS	WEAKNESS	TINGLING
X	N	S	W	T



WHAT IS YOUR PAIN LEVEL ON A SCALE OF 1 TO 10?



Chris S. Pallia, M.D.
Orthopaedic and Arthroscopic Surgery

INITIAL WORKCOMP HISTORY FORM

Name: _____ R L Handed Male/ Female

Date of Exam:_____ Date of Injury:_____ Wt: _____ Ht:_____
History of Injury:_____

_____

_____

_____

_____

_____

Course of Treatment:_____

_____

_____

_____

_____

Have any diagnostic studies been done? If so, what, where and when?

_____

_____

_____

Present chief complaint (worst body part to best), Rate pain 0 to 10 (10 is worst)

1. _____ Pain = _____
2. _____ Pain = _____
3. _____ Pain = _____
4. _____ Pain = _____
5. _____ Pain = _____

Employer at the time of injury:_____
Job Title:_____ Current work status:_____
Job Description:_____

_____

_____

Check all activities that apply to your job:

Pulling☐ Pushing☐ Grasping☐ Repetitive hand motions☐ Pinching ☐

Squeezing☐ Kneeling☐ Bending☐ Squatting☐ Twisting☐ Standing☐

Sitting☐ Overhead activities ☐ Max Wt Lifted _____ Other_____

Injury better when?_____ Worse when?_____
Hours worked per day_____ Hours per weeks_____ # of years_____
Last day of Work?_____

PREVIOUS DISABILITY HISTORY

Before this injury, had you ever missed work because of a work related injury? Yes☐ No☐

Have you had prior pain in involved body part Yes☐ No☐

Have you had prior motor vehicle accident? Yes☐ No☐

Prior workers comp injury? Yes☐ No☐ If yes give date_____

Injured body part? _____Employer_____

Did you return to the same duties you had before the injury? Yes☐ No☐

Did you have any work restrictions? Yes☐ No☐

Did you have any permanent Disability? Yes☐ No☐

If yes, what were your restrictions? _____

Military History_____

List any disability from military service? _____

PAST MEDICAL HISTORY

Circle if you have any of the following:

Diabetes	Cholesterol Problems	Stroke
Heart Disease/Chest Pain	Kidney Problems	Emphysema
High Blood Pressure	Ulcer / GERD	Asthma
Depression	Cancer	Addiction to alcohol / drugs
Easy Bleeding	History of Blood Clots	Psychiatric Problems
Hypothyroidism	Liver Problems (hepatitis)	Irregular heart beat

List all operations you have had and the approximate date or year you had them:

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

List any medications that you are currently taking and the dosage:

_____ _____

_____ _____

_____ _____

Please list any allergies or adverse reactions that you have had to medications:

Medication_____ Reaction_____

Other Allergies: ☐ Iodine ☐ Nickel ☐ Environmental ☐ Latex

SOCIAL HISTORY

With Whom do you live? **Alone Family Friends** Other_____

Do you smoke? Yes☐ No☐ If "yes", how many packs a day and for how many years?____

If you are a former smoker, when did you quit and for how long did you smoke?_____

Do you drink alcoholic beverage? Yes☐ No☐

If "yes" how much and how often do you drink?_____

Do you exercise on a regular basis? Yes☐ No☐ What type of exercise do you do?_____

Have you been in an alcohol or drug rehabilitation program? Yes☐ No☐

RECREATIONAL ACTIVITIES

What are your hobbies/sports interests (ie. gardening, cooking, crocheting, basketball etc.)

_____

_____

_____

FAMILY HISTORY

Please circle below if anyone in your immediate family has had any of the following:

Stroke	Heart Disease	Diabetes
Cancer	High Blood Pressure	Back Pain
Neck Pain	Depression	Drug/Alcohol Addition
Suicide	Arthritis	

ACTIVITIES OF DAILY LIVING

Please check all tasks you are <u>unable to complete</u>:

- ☐ Dress yourself including shoes
- ☐ Wash and dry yourself
- ☐ Take a bath
- ☐ Get on and off the toilet
- ☐ Cut your food
- ☐ Lift a full cup to your mouth
- ☐ Make a meal
- ☐ Write a note
- ☐ Type a message on a computer
- ☐ Use a telephone
- ☐ Work outdoors on flat ground
- ☐ Climb up 1 flight of stairs (10 steps)
- ☐ Stand
- ☐ Sit
- ☐ Recline
- ☐ Rise from a chair
- ☐ Run errands
- ☐ Light housework
- ☐ Feel what you touch
- ☐ Open car doors
- ☐ Turn faucets off and on
- ☐ Get in and out of a car
- ☐ Sleep
- ☐ Engage in sexual activity

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you have had in the last week:

GENERAL
Fever
Weakness
Fatigue
Appetite loss
Nighttime sweats
Shaking / chills

SKIN
Skin disease
Pigmentation changes
tumors/cancers
cysts

HEAD
Headaches
Loss of memory
Problem Concentrating

EYES/VISION
Blurred/double vision
Decreased vision
Itching, burning, tearing
Light sensitivity

CARDIOVASCULAR
Chest pain
Heart palpitations
High blood pressure
Shortness of breath
Feet/ankle swelling
Varicose veins

RESPIRATORY
Chronic cough
Asthma
Emphysema
Chronic bronchitis
Pneumonia
Tuberculosis
Coughing blood
Wheezing

GASTROINTESTINAL
Frequent indigestion
Nausea or vomiting
Abdominal pain
Frequent constipation
Frequent diarrhea
Blood in stools

EARS/NOSE/THROAT
Ear pain
Infection or discharge
Hearing decreased/ loss
Ringing in ears
Recurrent throat issues
Voice Changes
Dental disease
Sinus problems

GENITOURINARY
Painful/difficult urination
Blood in urine
Urine incontinence

MUSCULOSKELETAL
Other non-injury related issues
Multiple joint pains
Pain / cramping in calf

NEUROLOGIC
Convulsions
Loss of consciousness
Other non-injury issues

PSYCHIATRIC
Depression
Nervousness
Sleeping all day
Sleep Disturbance
Spontaneous crying
Emotional outburst
Thoughts of suicide

ENDOCRINE
Increased thirst
Increased appetite
Increased urination
Diabetes
Hair loss

HEMATOLIC
Bleeding gums
Easy bruising/bleeding
that's hard to stop

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AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by Chris S. Pallia, MD. Authorization is hereby granted for such treatment and procedures.

MEDICAL RECORD AUTHORIZATION

Chris S. Pallia, MD is authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney or welfare agency involved with case.

WORKERS' COMPENSATION PATIENTS

Coverage will be verified and the workers' compensation carrier billed directly. Please be advised that all patients whose expenses are being covered by workers' compensation are required to keep all scheduled medical appointments. Our office is required to notify worker's compensation carrier any time a patient misses a visit. Please be advised, missed appointments may affect the authorization of future visits or procedures.

PRIVATE INSURANCE PATIENTS

I certified that the information given by me is correct and accept full responsibility for all charges. I hereby assign and authorize payment directly to the above named doctor of all insurance benefits. If my current policy prohibits direct payment to the doctor, I hereby instruct and direct the insurance company to make out the checks to me and mail to Chris S. Pallia, MD. I authorize Chris S. Pallia, MD to deposit checks made out to me as payment on my account. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commissions or charges.

PERSONAL INJURY

No attorney: If you were in an accident and there will be a future settlement and you do not have an attorney, you are expected to make consistent payments as you receive treatment. You may be reimbursed for your payments if your case settles; however, you are responsible for your entire treatment, regardless of settlement amount.

With attorney: If you were in an accident and have an attorney, we must have a lien on file signed by you and your attorney. This will allow you to receive treatment without payment until your case settles. You are ultimately responsible for the bill regardless of settlement amount.

MEDICARE PATIENTS

I certify that the information given by me in applying for payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment or authorized benefits be made on my behalf. If Medicare is your primary insurance, we will bill Medicare directly. There may be some expenses Medicare will not cover, and therefore you will be expected to sign a waiver and pay at the time of service.

CASH PATIENTS

If you do not have insurance, payment for treatment is due at the time of service

CANCELLATION POLICY

Forty-eight (48) hours advance notice is required for cancelling appointment. There is a $50 charge for failed appointments.

I have read the above information, and I understand and agree with all items stated above as well as my financial obligation to Chris S. Pallia, MD.

Patient (Guardian) Signature	Print Name	Date Signed