SAN DIEGO SPORTS MEDICINE & ORTHOPAEDIC CENTER, INC.

Worker's Compensation Patient Registration

Last Name_____ First Name_____ Middle Initial_____
Date of Birth ____/____/_____ Age_____ Gender: ☐Female ☐Male
Social Security #____-___-_____ Email_____
Residential Address_____ City_____ State ___ Zip _____
Mailing Address_____ City_____ State ___ Zip _____
Home Phone (____)_____Cell Phone (____)_____Work Phone (____)_____
Marital Status: ☐ Single ☐ Married ☐Divorced ☐Widowed
Language: _____ Interpreter Needed? ☐ Yes ☐ No
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐Black/African American
☐ Native Hawaiian/Pacific Islander ☐White ☐ Decline to State
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to State

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Insurance Carrier Name_____ Claim #_____
Date of Injury ____/____/_____ Accepted Body Part(s) _____
Claims Billing Address_____
Adjuster Name_____ Adjuster Phone (____)_____
Adjuster Fax (_____)_____ Adjuster Email _____
Nurse Case Manager Name _____ Phone(____)_____
Employer Name_____ Phone (____)_____
Employer Address_____ City_____ State ___ Zip _____
Do you have an attorney? ☐ Yes ☐ No
If yes, Attorney Name _____ Phone (____)_____

Emergency Contact Name_____ Relationship_____
Emergency Contact Home Phone(_____)_____Cell Phone (_____)_____

(Optional) Contact Preferences: By checking the box below, I give San Diego Sports Medicine & Orthopaedic Center, Inc. permission to contact me and provide reminder notices via the following method: ☐Home Phone ☐Cell Phone (call) ☐ Cell Phone (text) ☐ Email (Check All That Apply)

Patient (or Guardian) Signature _____ Date _____

Worker's Compensation History Form

Patient Name (please print):_____ Date of Birth ____/____/_____

Type of Evaluation (circle one): WC Eval & Treat, QME, IME, Consult Only, 2nd Opinion

Employer at time of injury: _____ Job Title:_____
Basic work duties at time of injury:
_____
Did you work for another employer, work on the side for friend, or have a home based business at the same time as you worked for this employer? Yes/ No
If yes, name of employer and type of business_____
Please list any dates you did not work at all: From _____ to _____

History of Injury:
Tell in your own words what you were doing at the time of the specific injury and what happened. If there was no specific injury, state when and what you began to feel and all areas involved:
_____
_____
_____
Body part we are seeing you for: _____

Please describe the quality of the discomfort and/or pain that you are experiencing (check all that apply): Sharp____, Dull____, Throbbing____, Burning____, Shooting____
On a scale of 1 to 10, with 10 being worst, how bad is your pain? At rest: ___ At its worst: ___
Are there any other symptoms associated with your pain? (check any that apply): Locking____, Catching____, Giving out____, Tingling____, Lack of sensation (numbness)____, Other (please describe)_____
What, if anything, makes symptoms better?_____
What, if anything, makes symptoms worse?_____
What treatments, if any, have you already tried for this problem (ex. physical therapy, injections, surgery)? _____

Past Medical History (Work Injuries):
Have you had any other work related injuries? Yes / No If yes, dates of injury: _____
Areas Injured:_____

I understand and agree that all information provided including medical history is truthful and accurate.

_____ _____
Patient Signature Date

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& ORTHOPAEDIC CENTER, INC.

6719 Alvarado Road, Suite 200, San Diego, CA 92120
Tel: (619) 229-3932 Fax: (619) 582-2860
www.sdsm.net

Medication List

Medication Name	Dose	Frequency	For What Condition?

OR

☐ I am not currently taking any medications

Patient Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

San Diego Sports Medicine & Orthopaedic Center, Inc.
Lisa Sullivan, Privacy Officer
(619) 229-3932

I hereby acknowledge that I received a copy of this medical practice's ***Notice of Privacy Practices***. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian/conservator of an incompetent patient

Patient Name_____ DOB: _____

☐ I would like a printed copy of the ***Notice of Privacy Practices*** to take with me