The Ryu Hurvitz Orthopedic Clinic

PATIENT INFORMATION – WORK COMP

Last Name: ____________________________First: _________________________Middle: ________

Date of Birth: ____________SS#: ________________________Marital Status: ______Gender: M / F

Address: ____

City/State/Zip Code: ____

Phone Home: ______________________________ Mobile: _________________________________

Email: ____

Emergency Contact: _________________________________Phone Number: __________________

Employer: ________________________ Employer Phone Number: __________________________

Employer Address: ____

Preferred Pharmacy: _____________________

I hereby authorize discussion of my general medical condition, diagnosis, treatment, payment and health care options with: (Check all that apply)

( ) Spouse/Name______________________ ( ) Children/Name________________________

( ) Other/Name ______________________________

INJURY

Body Part Injured: _____________________( ) Right ( ) Left

Date of injury: _________________ Place of Injury: _____________________________________

Brief description of the injury: ____

PRIVACY NOTICE ACKNOWLEDGEMENT:

I acknowledge that a copy of the Notice of Privacy Practices from The Ryu Hurvitz Orthopedic Clinic has been made available to me. I am aware that a paper copy of this Notice will be provided at my request. **Initials:** ____________________

FINANCIAL POLICY

Please understand that payment of your bill is part of this treatment and care. Please remember that insurance is not a substitute for payment.
For your convenience, you will find the answers to a variety of commonly-asked questions below.

*We accept payment by cash, check, VISA, MasterCard or American Express.

The Ryu Hurvitz Orthopedic Clinic

*Your financial responsibility depends on a variety of factors: Deductible, Co-Insurance and Co-pays. You must also be eligible at the time of service. If you do not understand your benefits, please contact your insurance company member services for detailed explanation.

*It is the patient's responsibility to inform us promptly of any changes regarding insurance coverage, address or phone number.

*If you cannot make it to your appointment, we ask that you notify us or re-schedule your appointment *at least* 24 hours in advance.

*The Ryu Hurvitz Orthopedic Clinic has the right to send you to collections for any patient balance that is still outstanding after 3 monthly statements have been sent to you, or if patient balance is still outstanding 6 months after insurance has processed claims, unless arrangements have been made.

*If you are having surgery, the Surgery Coordinator will contact your insurance company for benefits and pre-certification/authorization. You may be required to pay a pre-surgical deposit, depending on your coverage and deductible.

*A parent or legal guardian must accompany patients who are minors on the patient's visits. This accompanying adult is responsible for signing all the paperwork on behalf of the patient.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayment, coinsurance, and deductible, are my responsibility.

I authorize my insurance benefits be paid directly to Dr. Richard Ryu, Dr. Graham Hurvitz or Dr. Jervis Yau.

I authorized Dr. Richard Ryu, Dr. Graham Hurvitz or Dr. Jervis Yau to release pertinent medical information to my insurance company when requested, or to facilitate payment of claim.

______________ ______________________________ ______________________

Date **Signature** **Printed Name**

2936 De La Vina Street, 1st floor, Santa Barbara, CA 93105 Telephone: 805-963-2729 Fax: 805-963-3818

THE RYU HURVITZ ORTHOPEDIC CLINIC
Problem Questionnaire

Last Name: ______________________ First Name: ______________________ Age: ________

1. **Where is your main problem?** ____

   Right ( )   Left ( )   Bilateral ( )

2. **Are you experiencing the following problems (circle all that apply):**

   1. Pain
   2. Night Pain
   3. Weakness
   4. Stiffness
   5. Unstable or Dislocating Joint
   6. Swelling
   7. Numbness
   8. Other (Explain)

3. **How did your problem start? Please Explain.**

   ____

   ____

4. **How long have you had this problem, approximately?** ______________________

   (Give # of days, weeks, months, or years)

5. **Is your problem (please circle):   Improving   Worsening   Staying the Same**

6. **Is your pain or problem (please circle):   Intermittent   or   Constant**

7. **What makes your problem worse?**

   1. Exercise
   2. Sitting
   3. Standing
   4. Walking
   5. Repetitive motions
   6. Overhead activities
   7. Coughing, Sneezing, Straining
   8. Rest
   9. Nothing
   10. Other (Explain)

   ____

8. **Are you right or left handed?** ________ Right ________ Left

9. **What helps your problem?** ____

10. **Have you had this problem before?   Yes or No   If yes, when and for how long?** ____________

11. **Have you had previous medical treatment for this?   Yes or No   (If yes, please explain)**

    ____

12. **Are you taking any medications specifically for this problem? If so, please specify:**

    ____

13. **Have you tried the following conservative options: (check the ones you have tried)**

    Physical therapy ( )
    Aleve/ Ibuprofen/ Advil/ Etc ( )
    Rest ( )
    Icing/ Hot Pads ( )
    Tylenol ( )
    Home Exercise ( )
    Aspiration ( )
    Steroid Injections ( )

14. Who is your primary care physician or internist? ______________________

15. What tests have you had for this problem? At what facility? ______________________

Xrays ( ) Nerve Test ((EMG) ( )
CT Scan ( ) Ultrasound ( )
MRI ( ) Other ______________________

16. If you are working, does your job require the following?

Heavy Lifting ( ) Extending Walking ( )
Frequent Bending or Lifting ( ) Continuous Standing ( )
Frequent Squatting or Kneeling ( ) Sitting ( )
Climbing ( ) Repetitive Motions ( )

17. On a scale of 1 to 10, how bad is your pain or problem now? ______________________

18. Please list all of your current medications and supplements?

1. ______________________ **6.** ______________________
2. ______________________ **7.** ______________________
3. ______________________ **8.** ______________________
4. ______________________ **9.** ______________________
5. ______________________ **10.** ______________________

19. Do you have any medication allergies? Yes or No If yes, please list allergy & reaction:

____

____

20. Do you have any food or metal allergies? Yes or No If yes, please list allergy & reaction:

____

21. Do you have a history of any of the following illnesses, please circle all that apply to you:

1. Heart Disease
2. High Blood Pressure
3. Diabetes
4. Blood Clots
5. Stroke
6. Hepatitis
7. Tuberculosis
8. Cancer: if yes, which type: ______________________

22. Do you have any other medical conditions? (please list) ______________________

____

23. Please list any prior surgeries with approximate date(s): ______________________

____

24. Does anyone in your immediate family have any major medical problems such as those listed above? Yes or No If yes, please explain: ______________________

____

25. Marital Status? Single Married Divorced Widowed Domestic Partner

26. Do you have any children? Yes or No If so, how many? ___________

27. What is your occupation: ____

28. Do you plan to apply to any of the following programs because of this problem?

Disability: Yes or No **Worker's Compensation: Yes or No**

29. What is your present work status?

Not Working **Part Time** **Full Time** **Retired**

30. Do you drink any alcohol? Yes or No How many drinks per week? _______________________

31. Do you smoke tobacco? Yes or No How many packs per week? _______________________

32. Do you use illicit drugs? Yes or No If so, what? ________________________________

33. Please check if you are currently having problems in the following areas.

Eyes ( )
Ear/ Nose/ Throat ( )
Cardiovascular/ Heart ( )
Respiratory ( )
Gastrointestinal ( )
Blood/ Thinning/ Clotting ( )
Integumentary/ Skin ( )
Neurological ( )
Psychiatric ( )
Endocrine/ Hormones ( )
Genitourinary ( )
Allergy/ Immunology ( )
Musculoskeletal- Other than the condition you are being seeing for today ( )

Please give details:

____

____

____

____

____

Weight: ______________ lbs and Height: _____________ft ______________ in

____

Signature of Patient, Parent, or Guardian: ______________________________________ Date: _________