WEST LA hand center

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REGISTRATION FORM

PATIENT INFORMATION

Patient's First Name: MI: Last:

Marital status: ❑ Decline to specify
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Race/Ethnicity: ❑ Decline to specify ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic/Latino ❑ Native America ❑ Other ❑ Unknown

Birth date: / /

Gender: ❑ M ❑ F

Level of Education: ❑ GED ❑ High School ❑ Associates ❑ Bachelors ❑ Masters ❑ Doctorate ❑ Other

Preferred Language: ❑ English ❑ Spanish ❑ Other

Address:	City:	State:	Zip Code:

Email Address:

Social Security Number:	Primary Phone ❑ Home ❑ Cell ❑ Work	Secondary Phone ❑Home ❑ Cell ❑ Work

Occupation: ❑Full Time ❑Part Time	Employer:	Work Phone Number:

Who may we thank for referring you? ❑ Dr. ______________________________ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Google ❑ Other ___________________________

Other family members seen here:

RESPONSIBLE PARTY

(Financially) Responsible Party - If self, write "self" only	Birth Date:	Employer:	Phone Number:

Occupation:	Address (If different):		Work Phone Number:

If the patient is a minor, who has the legal authority to consent to medical care on his/her behalf?

INSURANCE INFORMATION

(Give your insurance card(s) to the front office)

Primary insurance: ❑ Aetna ❑ Anthem Blue Cross ❑ Aetna ❑ Blue Cross ❑ Cigna ❑ Medicare
❑ Tri-Care ❑ Lien ❑ Workers Comp. ❑ Other

Subscriber's name - If self, write "self"	Subscriber's SSN:	Birth Date:	Policy Number:	Group Number:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other ______________________________

Secondary Insurance: (If applicable):	Subscriber's SSN:	Birth Date:	Policy Number:	Group Number:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other ______________________________

EMERGENCY CONTACT

Name:	Relationship to Patient:	Primary Phone:	Secondary Phone:

PATIENT INFORMATION

Do you have any **allergies**? ❑ None ❑ Dairy ❑ Environmental ❑ Gluten ❑ Iodine ❑ Contrast/Dye
❑ Penicillin ❑ Latex ❑ Local Anesthetics ❑ Seasonal ❑ Shellfish ❑ Sulfa
❑ Other____

What is the Reaction? ____

Smoking: ❑ Never smoker ❑ Current every day smoker ❑ Former smoker ❑ Current some day smoker

Alcohol: ❑ Denies ❑ Rare ❑ Occasionally ❑ Moderate

Current medications list (Please include herbs/supplements/vitamins): ❑ None
____
____
____

REASON FOR VISIT

Reason for Visit: ____
Date on onset or injury: _____ /____ /________
Was the injury/onset related to: ❑ Auto Accident ❑ Work ❑ Other ____________________
Is this injury going to be in litigation? ❑ Yes ❑ No
Any Previous treatment for this issue? ❑ Yes ❑ No
If yes, who was the treating physician? ______________________________________

Dominant Hand? ❑ Right ❑ Left ❑ Ambidextrous

Rate your pain today on a scale of 0 - 10 (0 is no pain and 10 is the worst it can be) _________________________
Is the pain constant? ❑ Yes ❑ No If No, how long does pain last? ____________________________

When do you feel pain? ❑ Never ❑ All Day ❑ Morning ❑ Afternoon ❑ Evening
❑ Over night ❑ Increase over the day ❑ Decrease over the day

Character of pain? ❑ Achy ❑ Burning ❑ Cramping ❑ Dull ❑ Incapacitating
❑ Prickly ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing

Associated symptoms? ❑ Bruising ❑ Fatigue ❑ Giving way ❑ Locking ❑ Numbness
❑ Radiating pain ❑ Tenderness ❑ Tingling ❑ Swelling

What alleviates symptoms? ❑ Bracing ❑ Cold ❑ Elevation ❑ Heat ❑ Injections
❑ Position ❑ Medication ❑ Therapy ❑ Other ______________________

FAMILY HISTORY

Do any medical conditions run in **your family**? (Mark all that apply) ❑ None/Unknown

Condition	Mother's Side	Father's Side
Anemia		
Arthritis		
Bleeding Disorder		
Cancer		
Diabetes		
Gastrointestinal Issues		
Heart Disease		

Condition	Mother's Side	Father's Side
HIV/AIDS		
Hypertension		
Kidney Disease		
Leukemia		
Stroke		
Tuberculosis		
Respiratory Problems		

List other family conditions not listed above: ____

Patient Name ___________________________________ Age _____ Height ______ Weight _______

HEALTH HISTORY

Do **YOU** have any medical conditions? (Mark all that apply) ❑ None/Unknown

Past/Present		
Condition	**Yes**	**No**
Anemia		
Arthritis		
Asthma		
Bleeding disorder		
Cancer		
Depression		
Diabetes		
Gastrointestinal issues		
Glasses/Contacts		
Glandular problems		
Glaucoma		
Heart disease		
HIV/AIDS		
Hypertension		
Kidney disease		
Leukemia		
Osteoarthritis		
Osteopenia		
Osteoporosis		
Paralysis in arms or hands		
Psoriasis		
Respiratory problems		
Rheumatoid arthritis		
Stroke		
Thyroid- Hypo		
Thyroid- Hyper		
Tuberculosis		

In the last 6 months		
Condition	**Yes**	**No**
Good general health		
Abdominal pain		
Broken bones		
Changes in finger nails		
Chest pains		
Confusion		
Cough		
Diagnosed as a “bleeder”		
Heart trouble		
Excessive thirst		
Fatigue		
Hearing problems		
Hormone problems		
Insomnia		
Joint pain		
Memory loss		
Muscle pain/Cramps		
Nausea		
Night sweats/Fevers		
Numb/Tingling in arms or hands		
Palpitations		
Shortness of breath		
Sinus Problems		
Skin disorders		
Sore throat		
Stiff/Swollen joints		
Swollen hands/feet		
Vision problems		
Vomiting		
Weight change		

Other conditions not mentioned above:

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PAST SURGICAL HISTORY

Please list past surgeries: ❑ None

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