SOUTHERN CALIFORNIA ORTHOPEDIC AND REHAB SPECIALISTS
3420 Bristol St • Suite 700 • Costa Mesa • CA 92626
Tel.714.485.3599• fax.714.485.3544

Office use only:

TYPE:
DOI: _____ /______ /_______
Mo Day Yr

Patient History Form

Today's Date: ______ /_______ /________
Mo Day Yr

Patient's Name: ____

Date of Birth: _______/______/________ Age: ________ Right or Left Handed (circle one)

Height: ___________________ Weight: __________________

Sex (circle): ☐ M ☐ F **Marital Status:** ☐Single ☐Married ☐Other

Address: ____

City, Zipcode: ____

Phone No.: (________) ____________________ Email: ____________________

Emergency Contact: __________________________ Relationship: ________________

Tel: _________________________

Your Attorney's Name: ______________________________

Phone No.: (__________) ____________________

Interpreter Service: _____________________

Pharmacy Name: __________________________

Pharmacy. Tel: __________________________

HISTORY OF INJURY

Part 1

FOR MOTOR VEHICLE ACCIDENTS # of vehicles involved in the accident: ____________

(SKIP THIS SECTION IF YOU WERE NOT INVOLVED IN A MOTOR VEHICLE ACCIDENT:

Location where injury or accident occurred: ______________________________

Type of vehicle you were in: ______________________________

Type of vehicle that hit you: ______________________________

Your position in the vehicle: ❑ Driver ❑ Front seat passenger

❑ Back seat passenger: ❑ Right ❑ Middle ❑ Left

❑ Third row back seat passenger: ❑ Right ❑ Middle ❑ Left

Collision Type:

❑Driver side impact ❑Head On Collision ❑Passenger side impact ❑Rear Impact ❑Front Impact ❑Pedestrian Incident

Your vehicle was ❑moving ❑ stopped

Was a police report taken? ❑YES ❑ NO Did the ambulance arrive? ❑YES ❑ NO

Did you have restraints on (seatbelt/lap belt)? ❑YES ❑ NO

Did the airbag inflate? ❑YES ❑ NO ❑Car does not have airbag

If the air bag inflated, did it exert a loud noise? ❑YES ❑ NO

If the airbag inflated, did it impact your face? ❑YES ❑ NO

Did you lose consciousness? ❑YES ❑ NO

Did any of your body strike the vehicle? ❑YES ❑ NO

If YES, where? ______________________________

Position of YOUR head at time of impact:

❑Facing straight ahead ❑Tilted forward ❑Rotated to the left ❑Rotated to Right

Position of YOUR body at the time of Impact:

❑Straight ❑Tilted forward ❑Rotated to the left ❑Rotated to the right.

Part 2

FOR ALL PERSONAL INJURIES PLEASE COMPLETE THE FOLLOWING QUESTIONS

Who took you to the hospital?: ❑Ambulance ❑Other ______________________________

Hospital that you were taken to: ______________________________City ______________________________

How long did you stay at the hospital: ______________________________

How did the accident happen? (Use the back of this page if you need additional room)

____

____

____

____

____

____

____

Immediately after the accident, did you feel: ❑Dizzy, ❑Dazed, ❑ Disoriented, ❑Weak, ❑Nervous, ❑Nauseated

In what areas did you **IMMEDIATELY** feel pain?

☐Headaches	L☐	R☐	Both☐	☐Ribs	L☐	R☐	Both☐
☐Jaw	L☐	R☐	Both☐	☐Forearm	L☐	R☐	Both☐
☐Eye	L☐	R☐	Both☐	☐Hand	L☐	R☐	Both☐
☐Neck	L☐	R☐	Both☐	☐Hip	L☐	R☐	Both☐
☐Upper Back	L☐	R☐	Both☐	☐Leg	L☐	R☐	Both☐
☐Mid Back	L☐	R☐	Both☐	☐Knee	L☐	R☐	Both☐
☐Low Back	L☐	R☐	Both☐	☐Foot	L☐	R☐	Both☐
☐Chest	L☐	R☐	Both☐	☐Ankle	L☐	R☐	Both☐
☐Abdomen	L☐	R☐	Both☐				

Part 3. TREATMENTS THAT YOU HAVE RECEIVED FOR YOUR INJURY: ❑None

Have you had physical therapy: ❑Yes ❑No
When did you start? ______________________________ Length of treatment:____
Name of provider:

Did physical therapy help? ❑Yes ❑No How long does the relief last?
____

Have you had acupuncture?: ❑Yes ❑No
When did you start? ______________________________ Length of treatment:____
Name of provider:

Did acupuncture help? ❑Yes ❑No How long does the relief last?
____

Have you had chiropractic treatment?: ❑Yes ❑No
When did you start? ______________________________ Length of treatment:____
Name of provider:

Did chiropractic therapy help? ❑Yes ❑No How long does the relief last?
____

Have you had epidural(s) injection: Does it help? ❑Yes ❑No
If YES, did your pain come back? ❑Yes ❑No Time frame your pain returned after the epidural injections:__________________
If YES, which body part did you receive the injection? ❑Neck ❑Mid back ❑Low back
How many epidural injections did you receive? ________ in the neck. ________ in the mid back ________ in the low back.
Name of doctor who gave you injection(s): ____
Name of doctor who gave you injection(s): ____

Part 4 Tests done to evaluate your problem, the dates and the location they were done: ❑None

Study	Neck	Back	Date	Where
Plain X-rays	❑	❑		
Myelogram	❑	❑		
CT Scan	❑	❑		
MRI	❑	❑		
EMGs	❑	❑		
Bone Scan	❑	❑		

Part 5 List pain medications and dose taken for your pain: ❑None

Medication	Dose

MEDICATIONS: List all of your current medications including over the counter and health supplements. ❑None

Medication	Dose	Reason

ALLERGIES TO MEDICATIONS

Medication	Rash	Swelling, Wheezing, or Shock	Upset Stomach	Unknown Reaction	Other
	❑	❑	❑	❑	
	❑	❑	❑	❑	
	❑	❑	❑	❑	

SURGICAL HISTORY: Previous surgeries – List procedures, surgeon, and date

NAME OF PROCEDURE	SURGEON	DATE

REVIEW OF SYSTEMS: ❑Check all that apply ❑None apply

❑Reading glasses
❑Change of vision
❑Loss of hearing
❑Ear pain
❑Hoarseness
❑Nosebleeds
❑Difficulty swallowing
❑Morning cough
❑Shortness of breath
❑Fevers or chills
❑Heart or chest pain

❑Abnormal heartbeat
❑Swollen ankles
❑Calf cramps w/ walking
❑Poor appetite
❑Toothache
❑Gum trouble
❑Nausea or vomiting
❑Stomach pain
❑Ulcers
❑Frequent belching
❑Frequent diarrhea

❑Frequent Constipation
❑Hemorrhoids
❑Frequent urination
❑Burning on urination
❑Difficulty starting urination
❑Get up more than once every
❑Wake up at night to urinate
❑Frequent headaches
❑Blackouts
❑Seizures
❑Frequent rash

❑Hot or cold spells
❑Recent weight change
❑Nervous exhaustion
Women only:
❑Irregular periods
❑Vaginal bleeding
❑Frequent spotting
❑Other: ____________________

MEDICAL HISTORY: Check all that apply.

❑Heart attack
❑Heart failure
❑High blood pressure
❑Osteoarthritis
❑Rheumatoid arthritis
❑Anklyosing spondylitis
❑Gout
❑Osteoporosis

❑Diabetes
❑Stroke
❑Seizures
❑Mental illness
❑Kidney stones
❑Kidney failure
❑Cancer
❑Alcoholism

❑Lung disease
❑HIV
❑AIDS
❑Tuberculosis
❑Asthma
❑Blood clot in leg
❑Blood clot in
❑Stomach ulcers

❑Liver trouble
❑Hepatitis
❑Thyroid trouble
❑Bleeding disorders
❑Anemia
❑Serious injuries (explain)
❑Other:

FAMILY HISTORY

Is there a history of: Family member(s):

Cancer ❑Yes ❑No ____________________

Tuberculosis ❑Yes ❑No ____________________

Heart disease ❑Yes ❑No ____________________

Diabetes ❑Yes ❑No ____________________

SOCIAL HISTORY

What are your hobbies-sports? ____________________
Do you smoke (cigarettes- packs daily)?: ____________________cigs - packs per day
Do you drink alcohol (how much)?: ____________________
Are you currently pregnant? ❑Yes ❑No

Part 6 PREVIOUS INJURIES (Please list all previous auto or work related injuries):

Body part and Date injury	Cause of Injury	Treatment Status
1) ____________________	☐ Auto ☐ Work ☐ Other	☐ Injuries Resolved ☐ Still Treating
2)____________________	☐ Auto ☐ Work ☐ Other	☐ Injuries Resolved ☐ Still Treating
3)____________________	☐ Auto ☐ Work ☐ Other	☐ Injuries Resolved ☐ Still Treating

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

EXPLANATION:
The authorization for use of disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et seq., California Civil Code.

Patient Name:____ DOB: ____________________

Address:____ Tel:_______________

INFORMATION TO BE RELEASED FROM:

(office use only)

NAME/AGENCY:____

ADDRESS:____

CITY/STATE/ZIP:____

PHONE:____________________________________ FAX:_____________________________________

INFORMATION REQUESTED:____

INFORMATION TO BE RELEASED TO:

SOUTHERN CALIFORNIA ORTHOPEDIC REHAB SPECIALISTS

❑ 3420 Bristol St. # 700 Costa Mesa, CA 92626 Tel: 714-485-3599 Fax: 714-485-3544

__________**URGENT please fax to:** ❑ Fax: 714-485-3544 ❑

EMAIL:__________________________

I am aware of and/or have been advised of the provisions of existing State and Federal Statutes, Rules and Regulations which provide for my right to confidentiality of the information in these records.

I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released and that I may refuse to sign, but in that event the records cannot be released.

Date:_____________________________ Signature:_____________________________________

Signature of Parent/Guardian:____

Name and relationship to patient:____

SCORS
SOUTHERN CALIFORNIA ORTHOPEDIC
AND REHAB SPECIALISTS

3420 Bristol St • Suite 700 • Costa Mesa • CA 92626
Tel.714.485.3599• fax.714.485.3544

MEDICAL SERVICE LIEN

ATTORNEY: FACILITY/PROVIDER:

______________________________ Southern California Orthopedic & Rehab Specialists

______________________________ 3420 Bristol St., Ste 700

______________________________ Costa Mesa, CA 92626

PATIENT: ______________________________ DOI: ______________________________

TO: Attorney:

On behalf of myself, and successors, I do hereby agree to pay for and authorize the above PROVIDER/FACILITY to furnish you, my attorney, with a full report of the case history, examination, diagnosis, treatment(s), and prognosis of my health that was compromised as result of my injury or injuries sustained from and in connection to the accident which occurred/began on above date of injury (DOI).

I hereby AGREE to have a lien placed against my file/case by aforementioned FACILITY/PROVIDER OF ANY HEALTHCARE SERVICES in exchange for said PROVIDER to provide me with any medically necessary healthcare related services deemed medically necessary and appropriate per the standard of care required to return my health back to optimal condition as it was prior to the accident/injury. As agreed, said PROVIDER will provide these services prior to any settlement, claim, judgment or verdict as a result of said accident/injury. By signing this LIEN AGREEMENT, I the PATIENT/CLIENT agree and authorize and direct you, my attorney, to pay directly to said FACILITY/PROVIDER such sums as may be due and owing them for service(s) rendered to me, and to withhold such sums from such settlement, claim, judgement or verdict as may be necessary to protect said FAICLITY/PROVIDER adequately.

I fully understand that I am directly and personally responsible to said FACILITY/PROVIDER for payment of all surgery bills submitted by them for services rendered to me, and that this agreement is made solely for said FACILITY's additional protection and in consideration of them awaiting payment. I further understand that my financial responsibility of said payment is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee.

I, the undersigned, hereby certify that I accept total financial responsibility for the care/treatments rendered to me as the patient receiving healthcare services by the Surgery Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and all other ancillary providers. I understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to me by the Surgery Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers.

Dated: ______________________________ Patient's Signature: ______________________________

The undersigned being attorney of record for the above patient does hereby agree that this document serves as valid medical lien and agrees to observe all the terms of the above. The undersigned further agrees to abide by the ethical standards of the State Bar Rules and to first withhold such sums from any settlements, judgment award, or verdict as may be necessary to adequately protect and pay said PROVIDER above named for all the patient's medical expenses.

Dated: ______________________________ Attorney's Signature: ______________________________

To Attorney: Please date, sign and fax back to the PROVIDER's office at once.

SPECIALTY SURGERY CENTER
SOUTH COAST

3420 Bristol St • Suite 750 • Costa Mesa • CA 92626
Tel.714.708.3737 • fax.714.708.3773

MEDICAL SERVICE LIEN

ATTORNEY: FACILITY/PROVIDER:

___________________________________ SOUTH COAST SPECIALTY SURGERY CENTER

___________________________________ 3420 Bristol St., Ste 750

___________________________________ Costa Mesa, CA 92626

PATIENT: ______________________________ DOI: ___________________________

TO: Attorney:

On behalf of myself, and successors, I do hereby agree to pay for and authorize the above PROVIDER/FACILITY to furnish you, my attorney, with a full report of the case history, examination, diagnosis, treatment(s), and prognosis of my health that was compromised as result of my injury or injuries sustained from and in connection to the accident which occurred/began on above date of injury (DOI).

I hereby AGREE to have a lien placed against my file/case by aforementioned FACILITY/PROVIDER OF ANY HEALTHCARE SERVICES in exchange for said PROVIDER to provide me with any medically necessary healthcare related services deemed medically necessary and appropriate per the standard of care required to return my health back to optimal condition as it was prior to the accident/injury. As agreed, said PROVIDER will provide these services prior to any settlement, claim, judgment or verdict as a result of said accident/injury. By signing this LIEN AGREEMENT, I the PATIENT/CLIENT agree and authorize and direct you, my attorney, to pay directly to said FACILITY/PROVIDER such sums as may be due and owing them for service(s) rendered to me, and to withhold such sums from such settlement, claim, judgement or verdict as may be necessary to protect said FAICLITY/PROVIDER adequately.

I fully understand that I am directly and personally responsible to said FACILITY/PROVIDER for payment of all surgery bills submitted by them for services rendered to me, and that this agreement is made solely for said FACILITY's additional protection and in consideration of them awaiting payment. I further understand that my financial responsibility of said payment is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee.

I, the undersigned, hereby certify that I accept total financial responsibility for the care/treatments rendered to me as the patient receiving healthcare services by the Surgery Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and all other ancillary providers. I understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to me by the Surgery Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers.

Dated: ____________________________ Patient's Signature: ____

The undersigned being attorney of record for the above patient does hereby agree that this document serves as valid medical lien and agrees to observe all the terms of the above. The undersigned further agrees to abide by the ethical standards of the State Bar Rules and to first withhold such sums from any settlements, judgment award, or verdict as may be necessary to adequately protect and pay said PROVIDER above named for all the patient's medical expenses.

Dated: ____________________________ Attorney's Signature: ____

To Attorney: Please date, sign and fax back to the PROVIDER's office at once.

ANESTHESIA SERVICE LIEN

ATTORNEY: ____________________________________

FACILITY/PROVIDER:

ANESTHESIA PROVIDER/COMPANY:_________

HEALTHCHECK CORP

3420 Bristol St., Ste 320

Costa Mesa, CA 92626

____

____

____

PATIENT: ______________________________ DOI: ___________________________

TO: Attorney:

On behalf of myself, and successors, I do hereby agree to pay for and authorize the above ANESTHESIOLOGIST or PROVIDER REPRESENTATIVE to furnish you, my attorney, with a full report of the case history, examination, diagnosis, treatment(s), and prognosis of my health that was compromised as result of my injury or injuries sustained from and in connection to the accident which occurred/began on above date of injury (DOI).

I hereby AGREE to have a lien placed against my file/case by aforementioned ANESTHESIA PROVIDER OR ITS REPRESENTATIVE SERVICE COMPANY in exchange for said PROVIDER OF ANESTHESIA to provide me with any medically necessary healthcare related services deemed medically necessary and appropriate per the standard of care required to return my health back to optimal condition as it was prior to the accident/injury. As agreed, said PROVIDER will provide these services prior to any settlement, claim, judgment or verdict as a result of said accident/injury. By signing this LIEN AGREEMENT, I the PATIENT/CLIENT agree and authorize and direct you, my attorney, to pay directly to said PROVIDER/COMPANY such sums as may be due and owing them for service(s) rendered to me, and to withhold such sums from such settlement, claim, judgement or verdict as may be necessary to protect said COMPANY/PROVIDER adequately.

I fully understand that I am directly and personally responsible to said ANESTHESIA PROVIDER/COMPANY for payment of all anesthesia bills submitted by them for services rendered to me, and that this agreement is made solely for said PROVIDER'S COMPANY additional protection and in consideration of them awaiting payment. I further understand that my financial responsibility of said payment is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee.

I, the undersigned, hereby certify that I accept total financial responsibility for the care/treatments rendered to me as the patient receiving healthcare services by the PHYSICIAN OR PHYSICIAN'S REPRESENTATIVE and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and all other ancillary providers. I understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to me by the PROVIDER/COMPANY. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers.

Dated: ___________________________ Patient's Signature: ____

The undersigned being attorney of record for the above patient does hereby agree that this document serves as valid medical lien and agrees to observe all the terms of the above. The undersigned further agrees to abide by the ethical standards of the State Bar Rules and to first withhold such sums from any settlements, judgment award, or verdict as may be necessary to adequately protect and pay said PROVIDER/COMPANY above named for all the patient's medical expenses.

Dated: ___________________________ Attorney's Signature: ____

To Attorney: Please date, sign and fax back to the PROVIDER's office at once.

Pain Medication Contract

- I agree that the opiods will be prescribed by only one doctor, and I agree to fill my prescription at only one pharmacy. I agree not to take any pain medication or mind altering medication prescribed by any other physician without first discussing it with the above named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

- I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

- I agree not to sell, lend or in any way give my medication to any other person.

- I agree not to drink alcohol or take mood altering drugs while I am taking opioid analgesic medication. I agree to submit to a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and drugs.

- I agree that I will attend all required follow-up visits with the doctor to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.

- I understand that there is a risk that opioid addiction can occur. This means that I may become psychologically and/or physically dependent on the medication, using it to change my mood or "get high", or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addition. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem. I have read the above, asked questions, and understand the agreement.

- If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient Name:_____________________________________

Patient Signature: X______________________________ Date:_____________

Patient Email and Text Message Informed Consent

You may give permission to SCORS's Clinic staff to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/text communication, and how we use email/text communication. It also will be used to document your consent for communication with you by email and text message.

1. **How we will use email and text messaging**: We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your email and text messages may be forwarded to another SCORS staff member as necessary for appropriate handling. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
2. **Risk of using email and text messages**: The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to, the following:
   a. Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Senders can easily misaddress an email or text and send the information to an undesired recipient.
   c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect emails and texts sent through their company systems.
   e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f. Emails and texts can be used as evidence in court.
   g. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.
3. **Conditions for the use of email and text messages**: SCORS cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:
   a. **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911.** Do not email for urgent problems. If you have an urgent problem during regular business hours, please call your staff person, or 714-485-3599. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.
   b. Emails should not be time-sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within three days, call our office to follow up if we have received your email.
   c. You should speak with your staff person to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
   d. Email and text messages may be filed electronically into your medical record.
   e. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.
   f. You should use your best judgment when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
   g. SCORS is not liable for breaches of confidentiality caused by you or any third party.
   h. It is your responsibility to follow up with your staff person if warranted.
4. **Withdrawal of consent**: I understand that I may revoke this consent at any time by so advising SCORS in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.
5. **Patient Acknowledgement and Agreement**: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between SCORS staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that SCORS may impose to communicate with me by email or text message.

Your Email: ____

Your Cell: ____ Your Wireless Carrier: ___________________________________

Patient Name:________________________________

Patient Signature: **X**___________________________________ Date:_____________