ORTHOPEDIC INSTITUTE of SANTA BARBARA

Medical History

Name: _____ **Date:** _____ **DOB:** ____/_____/_____ **Age:** _____

Nickname (if applicable):_____ **Height:** _____ **Weight:** _____ **Hand Dominance:** R / L

Allergies (medications and/or metals): _____ NKDA / PCN / Sulfa / Latex

Occupation (if retired, what did you do?): _____ **Spouse/SO name:**_____

Primary Care Physician: _____ **Referred by:** _____

History of your injury: Which body part is to be examined: R / L _____

How did you get injured (detailed as possible):_____

_____

Date of Injury / Onset: _____ **Is this injury related to Worker's Compensation?** Y / N

How long have you had the condition? _____

Please rate and describe your pain:

0 None	1	2	3	4	5	6	7	8	9	10 Severe

Use the above scale to define the following: Pain at rest: _____ **Pain with Activity:** _____ **Night Pain:** _____

Is the pain (check if applicable): ☐ Constant ☐ Occasional ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing
☐ Throbbing ☐ Worse at night ☐ Activity inhibiting ☐ Other:_____

If any, what mechanical symptoms are you experiencing: ☐ Locking ☐ Catching ☐ Giving away ☐ Popping
☐ Grinding ☐ Other:_____

The pain is worse with (ex- stairs): _____ **and better with:**_____

Have you ever seen a physician for this injury before: No / Yes **:** _____

What previous treatment(s) have you tried? ☐ Nothing ☐ Physical Therapy ☐ Bracing ☐ Chiropractic
☐ Injections (If so, when and what type?)_____
☐ Surgery/Other (describe):_____

Do you have any recent: ☐ **Xrays Date:**_____ **Location: Pueblo / Cottage** _____
☐ **MRI Date:**_____ **Location: Pueblo / Cottage** _____

Medications Currently taking:_____

_____

Preferred Pharmacy:_____

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History of previous fractures & dates: _____

History of surgeries & dates (Please mention R or L and which surgeon):_____

_____

_____

✱ **History of previous blood clots: No / Yes Dates:**_____

✱ **List any prior dental issues, infections, or surgeries:**_____

Please indicate your use of the following per day (leave blank if none):

Coffee: ____ Alcohol: ____Tobacco: Current_____ / Former, stopped in_____ **Recreational Drugs:**_____

Hobbies: _____

What sports or activities do you participate in and/or what are your athletic goals? _____

_____

Gastrointestinal History:

Do you have a history of peptic Ulcer Disease: No / Yes- when? _____
Do you have a history of GI or stomach bleed? No / Yes- when? _____
Do you take any medications for your stomach? No / Yes- what? _____

Please check below if any of these apply to you:

☐ **Diabetes, Type: I / II**	☐ **Heart disease**	☐ **DVT (Blood clots)**	☐ **Depression**
☐ **Osteoporosis**	☐ **Chest pain**	☐ **Pulmonary Embolus**	☐ **Cancer**
☐ **Osteoarthritis**	☐ **Arrhythmia**	☐ **Strokes/Seizures**	☐ **Recent weight loss**
☐ **Osteopenia**	☐ **Pacemaker**	☐ **Epilepsy**	☐ **Loss of appetite**
☐ **Rheumatoid Arthritis**	☐ **Circulation problems**	☐ **Sex Dysfunction**	☐ **Polio**
☐ **Fibromyalgia**	☐ **Bleeding/clotting**	☐ **Claustrophobic**	☐ **Nausea**
☐ **Parkinson's**	☐ **Bloody urine**	☐ **Fainting Problems**	☐ **Constipation**
☐ **Thyroid Disease**	☐ **Headaches**	☐ **Lapse of memory**	☐ **Pneumonia**
☐ **Urination problems**	☐ **Blood transfusion**	☐ **HIV**	☐ **Shaking/twitching**
☐ **Gout**	☐ **Calf cramps w/walking**	☐ **Hepatitis**	☐ **High/Low BP**
☐ **Emotional illness**	☐ **History of Infections**	☐ **Dental Issues**	☐ **Lupus**

If you put a check next to any of the above items, please explain:

_____

_____

Family history of medical conditions: _____

_____**Death before age 50:** No / Yes

Thank you for taking the time to fill out this form- it helps us provide you with the best orthopedic care

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PATIENT INFORMATION

Primary Care MD:_____

Referred By:_____

Body part being treated:_____

Have you ever been seen by Dr. William R. Gallivan, Jr. MD: ☐ Yes ☐ No

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Patient's Name:_____ ☐ Male ☐ Female
First Middle Last

Birth date:___/___/____ Age:_____ Driver's Lic:_____ SSN:_____-_____-_____

Address:_____ , _____, _____, _____
Street or Box Number City State Zip

Phone: ( )_____ Cell: ( )_____

Email:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone: ( )_____

Employer Name:_____ Occupation:_____

Employer Phone: ( )_____

Date of Injury / Accident:____/_____/_____

Attorney Name:_____ Phone: ( )_____

William R. Gallivan, Jr. MD
Santa Barbara Office 320 W. Junipero, Santa Barbara, CA 93105
Solvang Office: 2040 Viborg Rd Ste 230 | Solvang, CA 93463
Phone: 805-220-6020 | **Fax**: 805-284-0085

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INSURANCE INFORMATION

Responsible Party if minor:_____

Relationship:_____

Driver's Lic:_____ SSN:_____-_____-_____

Phone: ( )_____

Private / Medicare Insurance Information

Primary Insurance:_____ Member ID:_____

Group #:_____ Effective Date:_____

Subscriber Name:_____ Date of Birth: ____/____ /_____

Secondary Insurance:_____ Member ID:_____

Group #:_____ Effective Date:_____

Subscriber Name:_____ Date of Birth: ____/____/_____

I hereby authorize my insurance benefits be paid directly to Orthopedic Institute of Santa Barbara (OISB), realizing I am responsible for all co-pays, deductibles, co-insurance and any non-covered service balances. I understand I am financially responsible for charges whether or not they are covered by insurance. I further authorize any holder of medical information about me to release information to OISB necessary to process my claim.

Signed:_____ Date:_____

We are required to submit claims with your name exactly as it appears on your insurance card. **Therefore, you must provide your insurance card and photo ID prior to services rendered.**

WORKER'S COMPENSATION INFORMATION

Is this Injury Work Related? ☐ Yes ☐ No If yes, please continue.

Insurance Carrier:_____

Address:_____

Employer At Time of Injury:_____ Date of Injury:____/____/_____

Claim#:_____Adjuster:_____

Phone: (_____)_____ Ext:_____ Fax: (_____)_____

Email:_____

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CONSENT FOR TREATMENT. I voluntarily consent to care, treatment, testing and all other services performed by health care providers at Orthopedic Institute of Santa Barbara (OISB). However, I understand that I have the right to refuse to consent to ANY proposed treatment, surgery, procedure or testing and I have the right to further discuss my concerns with my health care provider.

I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the result of the examination or treatment.

I understand that I can revoke this consent at any time in writing except to the extent that the office of OISB, has acted in reliance upon this authorization and that I do not have to sign this authorization in order to receive treatment from OISB at 320 West Junipero, Santa Barbara California 93015 or at 2040 Viborg Road, Suite 230, Solvang, California 93463.

RELEASE OF MEDICAL INFORMATION: I understand that OISB shall maintain a record of medical care that I receive from OISB. This medical record will typically include information about my symptoms, results of physical examinations and diagnostic tests, and plan regarding future care and treatment. This information is considered Protected Health Information (PHI) and, as such, will only be used or disclosed for the purpose of treatment, payment and healthcare operations and otherwise will not released without my specific consent except as required by law.

I am aware, however, that information concerning my medical treatment and services rendered on my behalf may be released as necessary, to health care providers in emergent situations or to receive payment by public and private health insurance plans as outlined in OISB Financial Policy:_____(initials)

PATIENT RIGHTS AND RESPONSIBILITIES: I understand that the office of OISB, assumes no responsibility for the use of misuse by others of my PHI disclosed under this authorization. I release the office of OISB, its agents and employees from all legal liability that may arise from this authorization._____(initials)

ADVANCE DIRECTIVES: Adults 18 years and older have the right to give directions about their future medical care or to designate another person(s) to make medical decisions if they lose decision making capacity._____(initials)

I have read and understand this form and all of my questions have been answered to my satisfaction.

PATIENT SIGNATURE:_____D.O.B.:_____

PATIENT NAME:_____DATE:_____
(PRINT)

Parent/Guardian:_____DATE:_____
(SIGN)

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