COASTALORTHO ADVANCED ORTHOPEDICS

FORMERLY KNOWN AS
TORRANCE ORTHOPAEDIC & SPORTS MEDICINE GROUP

Referred By: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Nickname: _____ **Gender: M / F** **Date of Birth:** _____/_____/_____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security #: _____-_____- _____ **Marital Status: Single / Married / Divorced / Widowed**

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

E-Mail address: _____ **Ethnicity:** _____ **Language:** _____

Employer: _____ **Employer Tel:** (_____) _____

Emergency Contact: _____ **Tel:** (_____)_____ **Relationship :**_____

Were you injured on the job? ☐ Yes ☐ No **Injured due to an auto accident? ☐ Yes ☐ No**

INSURANCE INFORMATION

Primary Insurance: _____
Insured's Name: _____
Relationship to patient: Self / Spouse / Partner/ Dependent
Insured's DOB: _____ /_____ /_____
ID#: _____

Secondary Insurance: _____
Insured's Name: _____
Relationship to patient: Self / Spouse / Dependent
Insured's DOB: _____ /_____ /_____
ID#: _____

CONSENT FOR MEDICAL TREATMENT & ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Torrance Orthopaedic & Sports Medicine Group DBA Coastal Ortho to release any information required to process my claims.

Signature of patient (parent if minor): _____ **Date:** ____/ ____/ ____

PRESENT COMPLAINT

Reason for Visit/Body Part: _____ ☐ Right ☐ Left ☐ Both

Onset: ___ / ___ / ___ ☐ Sudden ☐ Gradual **If gradual for how long?** _____

Severity of Pain: ☐ Mild ☐ Moderate ☐ Severe **Frequency of Pain:** ☐ Rare ☐ Occasional ☐ Intermittent ☐ Constant

Status of Pain: ☐ Fluctuating ☐ Stable ☐ Worse ☐ No pain **Quality of Pain:** ☐ Aching ☐ Dull ☐ Sharp ☐ Shooting ☐ Throbbing

Does Your Pain Radiate: ☐ Yes ☐ No **If so, to where?** _____

If due to an injury, please describe: _____

Aggravated By: ☐ Bending ☐ Lifting ☐ Movement ☐ Walking ☐ Sitting ☐ Standing ☐ Pushing ☐ Pulling ☐ Stairs

Relieved By: ☐ Splint ☐ Ice ☐ Heat ☐ Massage ☐ Therapy ☐ Elevation ☐ Exercise ☐ Stretching ☐ OTC medicines

Associated Symptoms: ☐ Bruising ☐Instability ☐ Tenderness ☐ Weakness ☐ Numbness ☐ Tingling
☐ Swelling ☐ Limping ☐ Locking ☐ Decreased mobility

YOUR DOCTORS:

Please list your current doctors and their specialties

Doctor	Specialty	Doctor	Specialty
1.		3.	
2		4.	

ALLERGIES

Please list any known allergies that you are aware of, along with the reactions

Allergy:	Reaction:

MEDICATIONS

Please list all current medications (or attach medication list):

Pharmacy: _____ **Address:** _____ **Phone:** (____) _____-_____

Medication	Strength	Directions	Medication	Strength	Directions
1.			5.		
2.			6.		
3			7.		
4.			8.		

MEDICAL CONDITIONS

Please list your medical conditions

1.	4.
2.	5.
3.	6.

SURGERIES

Please list all current medications

Surgery	Laterality	Year	Surgery	Laterality	Year
1.			4.		
2.			5.		
3.			6.		

FAMILY MEDICAL HISTORY

RELATIVE:	STATUS:	AGE:	MEDICAL CONDITIONS:	CAUSE OF DEATH (if applicable)
Mother	☐ Alive ☐ Deceased			
Father	☐ Alive ☐ Deceased			

SOCIAL HISTORY

Occupation: _____ **Height:** _____ **Weight:**_____ **Hand dominance:** ☐ Right ☐ Left

Do you use tobacco products: ☐ Yes ☐ No **Tobacco products used:** ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigar

Quit Date (former smoker): ____ / ____ / ____ **How many cigarettes per day?** _____ **For how many years?** _____

Do you consume alcohol: ☐ Yes ☐ No **If so, how often?** _____

Do you have history of alcohol abuse? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No If so, what type? _____