SAN DIEGO
HANDSPECIALISTS
CARE OF THE HAND & UPPER EXTREMITY

8008 FROST STREET · SUITE 403 · SAN DIEGO CA 92123
TEL 858-715-9200 FAX 858-715-9202

DORI NEILL CAGE, M.D.
GREGORY R. MACK, M.D.
RISHI JINDAL, M.D.
JULIE R. OHAYON, M.D., F.A.C.S
RICHARD D. PERLMAN, M.D., M.P.H, F.A.C.
LINDSEY S. URBAND, M.D.

Date of Appointment:____________ Time:__________

PLEASE PRINT:

Patient Name:____________________ Middle Initial:____ Gender:_______

Date of Birth:_______ Age:____ SSN:______________ Marital Status:_____

Address:____

City: __________State: ____Zip Code:______________ Cell #:_____________

Home #:____________Can a message be left on your answering machine?_________

Height:________ Weight:_________ Are you right or left handed?___________

E-mail address:___________________________________

Family Physician: _____________Who Referred you to this office ? __________

Would you like your medical records sent to another office?

Office Name:______________ Phone#:______________ Fax#:____________

In case of emergency, whom may we contact? _____________Relationship?________

Phone #:_______________

EMPLOYMENT

PATIENT:
Employer: ________________________ Occupation: ________________FT/PT
Address:_________________________ Business Phone:______________
Are you currently working? Yes_______ No________
If the patient is a minor please fill out parent employment information above.

IF THIS IS A WORK RELATED INJURY/PROBLEM, PLEASE PROVIDE THE FOLLOWING WORK HISTORY **(Worker's Compensation only)**

When did you last work?

Are you working full duty?

If not, what are you current work restrictions? How long in you current status?

How long have you worked for your current employer?

How long have you been in this line of work?

Previous employment:

*******We will give you assistance in processing your insurance claim, however, you must understand that you are responsible for payment for all professional services and/or collection agency fees.*******

RELEASE OF INFORMATION AUTHORIZATION: I authorize the release of any medical information necessary to process claims to my insurance company. I agree that a photographic copy of this authorization shall be as valid as the original. If the patient is a minor, the signature found below shall be that of the patient's parent, guardian, or conservator.

AUTHORIZATION TO PAY PHYSICIAN: I hereby authorize payment directly to Dr. Dori Cage, Dr. Lindsey S. Urband, Dr. Gregory R. Mack, Dr. Richard D. Perlman, Dr. Rishi Jindal, and Dr. Julie R. Ohayon of the Medical Expense Benefits otherwise payable to me, but not to exceed my indebtedness to said physician on account of the enclosed charge.

PERSONAL RELEASE OF MEDICAL INFORMATION
I authorize the following person(s) to discuss or be provided information related to my medical care including billing matters. (This does not include medical personnel and insurance companies)

LANGUAGE PREFERENCE ____________________ ***ETHNICITY*** (optional)_______________

Name	Relationship
____________________	____________________
____________________	____________________
____________________	____________________

Print Patient's Name ____

____ Date: __________________
(Signature of Patient OR signature of Parent/Guardian if the Patient is a minor)

Witness Signature ________________________ Date: __________________

NOTICE TO CONSUMERS

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA (800) 633-2322

WWW.MBC.CA.GOV

ILLNESS & MEDICAL PROBLEMS:

Please mark relevant items and briefly explain:

- ☐ Glaucoma or other eye problems ______________________
- ☐ Pulmonary (asthma, wheezing, bronchitis, emphysema, pneumonia, tuberculosis, sleep apnea) ______________________
- ☐ Cardiac (hypertension, angina/chest pain, heart attack, heart murmur, irregular heartbeat) ______________________
- ☐ Bleeding tendency, easy bruising, nosebleeds, phlebitis, anemia)______________________
- ☐ Stomach, duodenal ulcers, or hiatal hernia ______________________
- ☐ Neurological problems (stroke, seizure disorder, paralysis)______________________
- ☐ Cancer (year, type, treatments)______________________
- ☐ Back pain or injury______________________
- ☐ Mental illness (depression, anxiety, schizophrenia, bipolar)______________________
- ☐ Alcohol/Drug Addiction/Withdrawal______________________
- ☐ Difficulty with anesthesia (if yes, which type)______________________
- ☐ Diabetes______________________
- ☐ Thyroid Problem______________________
- ☐ Other problems not listed above:______________________
- ☐ Exposure to Hepatitis, Tuberculosis, HIV/AIDS______________________

REVIEW OF SYSTEMS

Please circle any symptoms you are **currently** experiencing (**not limited to hands and upper extremities**)

General: Fatigue; Fever

Skin: Easy Bruising; Nail changes; Skin Color Changes

HEENT: Headache; Visual Changes

Neck: Pain

Respiratory: Cough; Difficulty Breathing; Sleep Apnea; Wheezing; Shortness of Breath

Cardiovascular: Chest Pain; Fainting/Blacking out; Phlebitis; Rapid Heart Rate; Irregular Heart Rate

Gastrointestinal: Heartburn; Other

Neurological: Numbness; Tingling; Burning Pain; Weakness in Extremities

Psychiatric: Anxiety; Depression; Insomnia

Endocrine: Thyroid Problems; Prostate Problems

Hematology: Abnormal Bleeding; Blood Clots

WHAT IS YOUR PRIMARY COMPLAINT? ______________________________

____

WAS THIS A SPECIFIC INJURY? IF SO, DATE OF INJURY: __/__/__
Please describe how it happened. ______________________________

____

Please list your hobbies or leisure activities (tennis, golf, knitting): ______________________

____

FAMILY HISTORY

	Yes	No		Yes	No		Yes	No
Carpal Tunnel	[ ]	[ ]	Rheumatoid	[ ]	[ ]	Heart Disease	[ ]	[ ]
Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]	Hypertension	[ ]	[ ]
Glaucoma	[ ]	[ ]	Arthritis	[ ]	[ ]	Blood Disorders	[ ]	[ ]
Cancer	[ ]	[ ]						

CURRENT MEDICATIONS:

Name of medication	Dose	Frequency

ALLERGIES

	Yes	No	Reactions:
Penicillin	[ ]	[ ]	
Tape	[ ]	[ ]	
Iodine	[ ]	[ ]	
Shellfish	[ ]	[ ]	

Please list other allergies and reaction: ______________________

			Amount:
Do you smoke	[ ]	[ ]	
Drink alcohol	[ ]	[ ]	

Please list all operations and hospitalizations:

Year	Operations	Hospital & Location