

12 Upper Ragsdale  
Ryan Ranch, Monterey, CA 93940

Tel: 831.648.7200 Fax: 831.648.7204  
montereyspineandjoint.com

220 San Jose Street  
Salinas, CA 93901

**Patient Information:**

First Name: \_\_\_\_\_  
Middle: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
DOB \_\_\_\_\_ Suffix: \_\_\_\_\_(Jr, Sr, etc)  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Cell #: \_\_\_\_\_  
Soc Sec #: \_\_\_\_\_  
Email: \_\_\_\_\_

please  here if you do *not* want MSJ email updates

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Pharmacy / Location: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Demographics:**

- Ethnicity:       Gender:       Marital status:
- Caucasian       male       single
- Hispanic       female       married
- Asian       domestic partner
- African American       divorced
- Other \_\_\_\_\_       widowed

**Referral Information:**  How did you hear about us?

- My physician referred me:  
(Name: \_\_\_\_\_)
- Friend:  
(Name: \_\_\_\_\_)
- Internet
- no one (self-referred)
- Other: \_\_\_\_\_

**Guarantor Information:** (person responsible for medical charges)

\* if patient is *not* guarantor, please fill out this section \*

First Name: \_\_\_\_\_  
Middle: \_\_\_\_\_ Gender: M F  
Last Name: \_\_\_\_\_  
DOB \_\_\_\_\_ Suffix: \_\_\_\_\_(Jr, Sr, etc)  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Cell #: \_\_\_\_\_  
Soc Sec #: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

**Insurance Information:**  None (self-pay)

	<input checked="" type="checkbox"/> Primary	<input checked="" type="checkbox"/> Secondary
Aetna	<input type="checkbox"/>	<input type="checkbox"/>
AARP	<input type="checkbox"/>	<input type="checkbox"/>
Anthem Blue Cross	<input type="checkbox"/>	<input type="checkbox"/>
Aspire	<input type="checkbox"/>	<input type="checkbox"/>
Blue Cross MCSIG	<input type="checkbox"/>	<input type="checkbox"/>
Blue Shield of California	<input type="checkbox"/>	<input type="checkbox"/>
Blue Shield Federal	<input type="checkbox"/>	<input type="checkbox"/>
CCAH	<input type="checkbox"/>	<input type="checkbox"/>
Cigna	<input type="checkbox"/>	<input type="checkbox"/>
Coastal TPA	<input type="checkbox"/>	<input type="checkbox"/>
Covered California	<input type="checkbox"/>	<input type="checkbox"/>
First Health	<input type="checkbox"/>	<input type="checkbox"/>
Health Net	<input type="checkbox"/>	<input type="checkbox"/>
Medi-cal	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>
Pinnacle	<input type="checkbox"/>	<input type="checkbox"/>
Tricare	<input type="checkbox"/>	<input type="checkbox"/>
Triwest	<input type="checkbox"/>	<input type="checkbox"/>
United ABT	<input type="checkbox"/>	<input type="checkbox"/>
United Healthcare	<input type="checkbox"/>	<input type="checkbox"/>
Western Growers	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	_____	_____
ID#: _____	_____	_____
Group#: _____	_____	_____

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**Medical History:**

Please  all that apply to you below or  none if N/A

Current Medications:  none  see attached

Type	Dose	Amount

- |                          | Yes                   | Comments: |
|--------------------------|-----------------------|-----------|
| Alzheimer's disease      | <input type="radio"/> |           |
| Arthritis – osteo        | <input type="radio"/> |           |
| Arthritis – rheumatoid   | <input type="radio"/> |           |
| Artificial Heart Valve   | <input type="radio"/> |           |
| Asthma                   | <input type="radio"/> |           |
| Atrial fibrillation      | <input type="radio"/> |           |
| Blood clot disorder      | <input type="radio"/> |           |
| Bleeding disorder        | <input type="radio"/> |           |
| Cancer                   | <input type="radio"/> |           |
| Cardiovascular disease   | <input type="radio"/> |           |
| Carotid artery surgery   | <input type="radio"/> |           |
| Congestive Heart Failure | <input type="radio"/> |           |
| COPD / emphysema         | <input type="radio"/> |           |
| Deep venous thrombosis   | <input type="radio"/> |           |
| Diabetes type I          | <input type="radio"/> |           |
| Diabetes type II         | <input type="radio"/> |           |
| Fibromyalgia             | <input type="radio"/> |           |
| GERD                     | <input type="radio"/> |           |
| Gout                     | <input type="radio"/> |           |
| High blood pressure      | <input type="radio"/> |           |
| High Cholesterol         | <input type="radio"/> |           |
| HIV / AIDS               | <input type="radio"/> |           |
| Heart murmur             | <input type="radio"/> |           |
| Heart attack             | <input type="radio"/> |           |
| Heart surgery            | <input type="radio"/> |           |
| Hepatitis                | <input type="radio"/> |           |
| Hypothyroidism           | <input type="radio"/> |           |
| Liver disease            | <input type="radio"/> |           |
| Multiple sclerosis       | <input type="radio"/> |           |
| Parkinson's disease      | <input type="radio"/> |           |
| Pain medicine addiction  | <input type="radio"/> |           |
| Peripheral neuropathy    | <input type="radio"/> |           |
| Pneumonia                | <input type="radio"/> |           |
| Pulmonary embolism       | <input type="radio"/> |           |
| Sciatica                 | <input type="radio"/> |           |
| Sleep apnea              | <input type="radio"/> |           |
| Sexually transmitted dz  | <input type="radio"/> |           |
| Stomach ulcers           | <input type="radio"/> |           |
| Stroke / CVA             | <input type="radio"/> |           |
| Tuberculosis             | <input type="radio"/> |           |

Prior Surgeries:  none  see attached

Type	Month/yr	Surgeon

Allergies to medication?  no  yes

Name of medication	Reaction

Allergies to food?  no  yes

(if applicable, list food & reaction) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies to latex?  no  yes

(if applicable, list reaction) \_\_\_\_\_  
 \_\_\_\_\_

Other medical conditions:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**Social History:**

Smoking history:                      No      Yes      Used to

Do you smoke?                           

   Day      Week      Month

      \_\_\_\_\_ # of packs per           

How many years?                      \_\_\_\_\_

When did you quit?                      \_\_\_\_\_

Drinking history:                      No      Yes      Used to

Do you drink alcohol?                     

   Day      Week      Month

      \_\_\_\_\_ # of drinks per           

How many years?                      \_\_\_\_\_

When did you quit?                      \_\_\_\_\_

Substance abuse history:

Do you use ...                      No      Yes      Used to

Marijuana                                   

Cocaine                                      

Methamphetamines                         

Heroin                                       

Intravenous drugs                         

Other                                      \_\_\_\_\_

Living situation:                      No      Yes

I live alone                                

 Please check  below who lives with you:

Husband                             

Wife                                    

Son                                      # \_\_\_\_\_

Daughter                              # \_\_\_\_\_

Brother                                # \_\_\_\_\_

Sister                                 # \_\_\_\_\_

Father                                

Mother                                

Boyfriend                             

Girlfriend                             

Domestic partner                     

Other                                    \_\_\_\_\_

**Work / School history:**

Are you employed?                      No      Retired      Yes

    

If so, what is your job? \_\_\_\_\_

Who is your employer? \_\_\_\_\_

If attending school, where? \_\_\_\_\_

If female, are you pregnant?              No      Possibly      Yes

    

 Please  if you enjoy these hobbies / activities:

Baseball	<input type="radio"/>	Rock climbing	<input type="radio"/>
Basketball	<input type="radio"/>	Running	<input type="radio"/>
Biking	<input type="radio"/>	Sailing	<input type="radio"/>
Crossfit	<input type="radio"/>	Scuba diving	<input type="radio"/>
Fishing	<input type="radio"/>	Skateboarding	<input type="radio"/>
Football	<input type="radio"/>	Soccer	<input type="radio"/>
Golf	<input type="radio"/>	Softball	<input type="radio"/>
Guitar	<input type="radio"/>	Surfing	<input type="radio"/>
Hiking	<input type="radio"/>	Swimming	<input type="radio"/>
Hockey	<input type="radio"/>	Tennis	<input type="radio"/>
Hunting	<input type="radio"/>	Violin	<input type="radio"/>
Knitting	<input type="radio"/>	Volleyball	<input type="radio"/>
Lacrosse	<input type="radio"/>	Wakeboarding	<input type="radio"/>
Painting	<input type="radio"/>	Walking	<input type="radio"/>
Piano	<input type="radio"/>	Water polo	<input type="radio"/>
Pilates	<input type="radio"/>	Working out	<input type="radio"/>
Racquetball	<input type="radio"/>	Yoga	<input type="radio"/>

Other : \_\_\_\_\_

\_\_\_\_\_

**Family History:**

Please list any medical conditions for the following family members:

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

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**Review of systems:** please  all that apply (feel free to comment on lines below)

- |  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|
| <b>General:</b>                        | <b>Eyes:</b>                              | <b>ENT:</b>                            | <b>Heart:</b>                             | <b>Lungs:</b>                                | <b>Stomach:</b>                         | <b>Urinary:</b>  |
| <input type="checkbox"/> none if N/A   | <input type="checkbox"/> none if N/A      | <input type="checkbox"/> none if N/A   | <input type="checkbox"/> none if N/A      | <input type="checkbox"/> none if N/A         | <input type="checkbox"/> none if N/A    | <input type="checkbox"/> none if N/A                       |
| <input type="checkbox"/> fevers        | <input type="checkbox"/> eye pain         | <input type="checkbox"/> sore throat   | <input type="checkbox"/> chest pain       | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> nausea         | <input type="checkbox"/> incontinence                      |
| <input type="checkbox"/> chills        | <input type="checkbox"/> eye discharge    | <input type="checkbox"/> hoarseness    | <input type="checkbox"/> palpitations     | <input type="checkbox"/> chronic cough       | <input type="checkbox"/> vomiting       | <input type="checkbox"/> urinary frequency                 |
| <input type="checkbox"/> fatigue       | <input type="checkbox"/> blurry vision    | <input type="checkbox"/> nose bleeds   | <input type="checkbox"/> rapid heart rate | <input type="checkbox"/> coughing up blood   | <input type="checkbox"/> heartburn      | <input type="checkbox"/> painful urination                 |
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> double vision    | <input type="checkbox"/> sinus problem | <input type="checkbox"/> heart murmur     | <input type="checkbox"/> excess sputum       | <input type="checkbox"/> diarrhea       | <input type="checkbox"/> frequent urinary tract infections |
| <input type="checkbox"/> night sweats  | <input type="checkbox"/> decreased vision | <input type="checkbox"/> ear pain      | <input type="checkbox"/> bad circulation  | <input type="checkbox"/> wheezing            | <input type="checkbox"/> constipation   | <input type="checkbox"/> blood in urine                    |
| <input type="checkbox"/> weight loss   | <input type="checkbox"/> dry eyes         | <input type="checkbox"/> ear discharge | <input type="checkbox"/> leg swelling     |  | <input type="checkbox"/> blood in stool |  |
| <input type="checkbox"/> weight gain   | <input type="checkbox"/> red eyes         | <input type="checkbox"/> hearing loss  |   |  |   |  |
| <input type="checkbox"/> insomnia      |   |  |   |  |   |  |

- |                                       |  |   |   |   |  |  |
|---------------------------------------|--|---|---|---|--|--|
| <b>Skin:</b>                          | <b>Bones/Joints:</b>                     | <b>Psychiatric:</b>                         | <b>Hormones:</b>                            | <b>Neurologic:</b>                      | <b>Blood:</b>                                | <b>Immune:</b>                               |
| <input type="checkbox"/> none if N/A  | <input type="checkbox"/> none if N/A     | <input type="checkbox"/> none if N/A        | <input type="checkbox"/> none if N/A        | <input type="checkbox"/> none if N/A    | <input type="checkbox"/> none if N/A         | <input type="checkbox"/> none if N/A         |
| <input type="checkbox"/> rash         | <input type="checkbox"/> joint pain      | <input type="checkbox"/> anxiety            | <input type="checkbox"/> increased thirst   | <input type="checkbox"/> tremors        | <input type="checkbox"/> easy bruising       | <input type="checkbox"/> allergic reactions  |
| <input type="checkbox"/> hives        | <input type="checkbox"/> joint swelling  | <input type="checkbox"/> depression         | <input type="checkbox"/> excess sweating    | <input type="checkbox"/> migraines      | <input type="checkbox"/> blood clots         | <input type="checkbox"/> frequent infections |
| <input type="checkbox"/> hair loss    | <input type="checkbox"/> muscle aches    | <input type="checkbox"/> panic attacks      | <input type="checkbox"/> heat intolerance   | <input type="checkbox"/> seizures       | <input type="checkbox"/> prolonged bleeding  |  |
| <input type="checkbox"/> skin sores   | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> drug dependence    | <input type="checkbox"/> cold intolerance   | <input type="checkbox"/> stroke         | <input type="checkbox"/> swollen lymph nodes |  |
| <input type="checkbox"/> skin ulcers  |  | <input type="checkbox"/> alcohol dependence | <input type="checkbox"/> skin color Changes | <input type="checkbox"/> slurred speech | <input type="checkbox"/> low blood counts    |  |
| <input type="checkbox"/> itching      |  | <input type="checkbox"/> suicidal thoughts  |   | <input type="checkbox"/> numbness       |  |  |
| <input type="checkbox"/> mole changes |  |   |   | <input type="checkbox"/> poor balance   |  |  |

Results normal?

- Date of last colonoscopy?  none \_\_\_\_\_(mo/yr)  yes  no
- Date of last mammogram?  none \_\_\_\_\_(mo/yr)  yes  no
- Date of last pneumonia vaccine?  none \_\_\_\_\_(mo/yr)

**Reason for Your Visit:**

What is the reason for your visit today?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have symptoms, how did they occur?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Release of Medical Information & Financial Responsibility:**

We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card. If a copayment or deductible is part of your plan, we require that your portion be paid at the time of service. We will make every effort to provide you with an accurate amount due at the end of your visit today.

I hereby authorize the release of any needed medical information to insurance carriers to process a claim, and request that payment be sent to Monterey Spine and Joint for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. Monterey Spine and Joint may add monthly rebilling fees for overdue balances.

\_\_\_\_\_  
Signature Date

**\*\*\*\* Medicare patients only \*\*\*\***

**Release of Medical Information & Financial Responsibility:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Monterey Spine and Joint for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable to related services.

I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is fully responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature Date

**Notice of Privacy Practices:**

I, \_\_\_\_\_ have been given the opportunity to read and review this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature Date

**Designation of Personal Representative**

I authorize the following person/persons to be my personal representative, which means the doctor and staff may speak freely to the named personal representative regarding all of my protected health information.

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

**Consent for Treatment if Patient is a Minor:**

I grant Monterey Spine and Joint and the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the stated patient.

\_\_\_\_\_  
Signature Relationship Date

