LAWRENCE LI, MD
ORTHOPEDIC & SHOULDER CENTER
Minimum Invasion • Maximum Result

LIABILITY REGISTRATION FORM

Account Number _____ Visit Date _____ Staff Initials _____

Patient Information

Legal Name		Preferred Name	Sex / Age
Street Address		Date of Birth	Marital Status
City, State, Zip Code		Email Address	
Home Phone *(if applicable)*	Cell Phone	Social Security Number	

Emergency Contact Information

Emergency Contact
Relationship to Patient
Emergency Contact Phone

Employment Information

Employer/Occupation	Date of Injury

Health Insurance Information

Name of Insurance Company	Relationship to Patient
Name of Insured	Subscriber DOB

Liability Information

Name of person handling this case	Date of accident	Place where accident/injury occurred	Phone # of person handling case
Were the police informed of the accident immediately? ☐ Yes ☐ No		Who is responsible, other than health insurance, for payment?	

Attorney Information (if applicable)

Attorney Name & Firm	Attorney Phone Number	Attorney Fax Number

Referring & Primary Care Physician Information

Physician who referred you	How did you hear about us? ☐ Internet ☐ Personal Referral _____ ☐ Advertisement ☐ Other _____
Primary Care Physician	

MEDICAL HISTORY FORM

Account Number _____ Visit Date _____ Staff Initials _____

Patient Information

Height	Weight	Are you right or left handed?

Medical Conditions

PLEASE CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING

☐ Asthma ☐ Insulin Diabetes ☐ Urinary Tract Infection ☐ HypoThyroid ☐ Gout

☐ Emphysema ☐ Non-Insulin Diabetes ☐ Hypertension (High Blood Pressure) ☐ Arthritis

☐ Cancer (please specify) :

Do you smoke Tobacco?	Do you drink alcohol regularly?	Do you use recreational drugs? *(If yes, please specify below):*
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please list any medical conditions you may have other than the ones stated above:

Please list all surgeries you have had:

Medications *(if you have a list, please ask the front to make a copy)*

Please list all medications, including over-the counter & herbals, with dosages, schedules, and reasons for currently taking them :

Please list all allergies to MEDICATIONS & your reaction below:	Are you allergic to Latex?
	☐ Yes ☐ No

Previous Treatments

HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES FOR THE INJURY WE ARE SEEING YOU FOR TODAY?

☐ XRAY ☐ MRI ☐ EMG/NCV ☐ CT SCAN ☐ Physical Therapy ☐ Occupational Therapy

If yes to any, please list **when** and **where** the procedure was performed:

LIABILITY INJURY FORM

Account Number _____ Visit Date _____ Staff Initials _____

Injury Details

What is bothering you?

Which body part(s) are affected? *(Please circle **left or right** side):*

☐ Neck ☐ L / R Shoulder ☐ L / R Wrist ☐ L / R Knee ☐ L / R Foot

☐ Back ☐ L / R Elbow ☐ L / R Hand ☐ L / R Ankle ☐ L / R Hip

☐ Other: _____

Is your problem from an injury or from overuse?

If injury, what is the date and approximate time of your injury?

Where did your injury occur?

Have you reported the injury to work? ☐ Yes ☐ No

When did you report the injury to work?

Was a written report filed? ☐ Yes ☐ No

What medical care providers have you seen for this work injury?

Did you ever have a problem in the same body part before this injury? ☐ Yes ☐ No

Are you still working? If yes, are there any restrictions? *(Please specify below):* ☐ Yes ☐ No

What is your job title and duties?

How long have you had this title?

When did you start working for this employer?

Is your claim? ☐ Accepted ☐ Disputed ☐ Unknown

Pain & Symptoms

If applicable, is your pain? ☐ Sharp ☐ Dull ☐ Aching

If applicable, is your pain? ☐ Occasional ☐ Frequent ☐ Constant

If applicable, is your pain? ☐ Mild ☐ Moderate ☐ Slight ☐ Severe

Min pain level: _____

Max pain level: _____

What makes the pain worse/better?

_____ ____/____/____

Signature of Patient/Parent/Guardian: ***Date:***