



LAWRENCE LI, MD
 ORTHOPEDIC & SHOULDER CENTER

Minimum Invasion • Maximum Result

WORK COMP 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

Work Comp Insurance Information

Name of Work Comp Carrier	Case Manager/Adjuster Name & Email Address
Work Comp Claim Number	Case Manager/Adjuster Phone & Fax Number

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?
Primary Care Physician	<input type="checkbox"/> Internet <input type="checkbox"/> Personal Referral _____ <input type="checkbox"/> Advertisement <input type="checkbox"/> Other _____

Patient Information

Height	Weight	Are you right or left handed?
--------	--------	-------------------------------

Medical Conditions

PLEASE CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING

- | | | | | |
|------------------------------------|---|---|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Insulin Diabetes | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> HypoThyroid | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Non-Insulin Diabetes | <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Arthritis | |

Cancer (please specify) :

Do you smoke Tobacco?

- Yes No

Do you drink alcohol regularly?

- Yes No

Do you use recreational drugs? *(If yes, please specify below):*

- 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?

- | | | | | | |
|-------------------------------|------------------------------|----------------------------------|----------------------------------|---|---|
| <input type="checkbox"/> XRAY | <input type="checkbox"/> MRI | <input type="checkbox"/> EMG/NCV | <input type="checkbox"/> CT SCAN | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy |
|-------------------------------|------------------------------|----------------------------------|----------------------------------|---|---|

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

Injury Details

What is bothering you?

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

- | | | | | |
|---------------------------------------|---|--------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> L / R Shoulder | <input type="checkbox"/> L / R Wrist | <input type="checkbox"/> L / R Knee | <input type="checkbox"/> L / R Foot |
| <input type="checkbox"/> Back | <input type="checkbox"/> L / R Elbow | <input type="checkbox"/> L / R Hand | <input type="checkbox"/> L / R Ankle | <input type="checkbox"/> L / R Hip |
| <input type="checkbox"/> 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: