

MISSION VALLEY MEDICAL CLINIC
 5333 Mission Center Road, Suite 100 • San Diego, CA 92108 • (619) 295-3355
 www.missionvalleymedical.com

PATIENT REGISTRATION (PLEASE PRINT)

Patient's Name _____
 Last First Middle Social Security Number _____

Date of Birth _____ Sex: M F
 Mo Day Yr Age

Home Address: _____
 Street Apt # City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____ Occupation _____

Work Address: _____
 Street Apt # City State Zip

Driver's License No: _____

Allergies to Medications: _____

Conditions Seeking Treatment For: _____

How Did You Hear Of Our Facility? _____

Emergency Contact: _____ Relation: _____ Telephone Number: _____

Address: _____

Nearest Relative Not Living With You: _____ Relation: _____

Address: _____ Telephone Number: _____

Primary's Name: _____ Date of Birth: _____
 Mo Day Yr Social Security Number _____

Address _____
 Street City State Zip

Sex: M F Phone: _____

Spouse's Name : _____ Phone: _____

AUTHORIZATION:
 I understand that I am financially responsible for all charges, whether or not covered by my insurance company. I hereby consent to medical treatment/physical examination; I also consent that you may contact me via email regarding outstanding balances and/or address corrections.

ASSIGNMENT:
 I permit payment directly to Drs. Office any benefits due for their services rendered.

Office use only
Initial

MEDICAL RECORDS:
 Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim for negotiating a settlement on a disputed claim.

WORKERS' COMPENSATION CLAIMS
 I Hereby certify that the information I have provided, regarding my industrial injury, is true and correct. (ANYONE WHO KNOWINGLY MAKES A FALSE OR FRAUDULENT STATEMENT TO OBTAIN OR DENY SOMEONE WORKERSCOMPENSATION BENEFITS COULD BE GUILTY OF A FELONY:

Signature : _____ Date _____

Signature of Parent/Guardian: _____ Relationship to Patient _____

Name: _____

Title: _____

Each applicant for employment is requested to answer all the following questions so that they may be assigned to work in accordance with the Occupational Safety and health Act of 1970. If disabilities or deficiencies are present, please give details under COMMENTS. This will assist us in determining what modifications may be required, if any, for appropriate job placement under the Rehabilitation Act of 1973 and the American with Disabilities Act of 1990.

PART I: (APPLICANT TO COMPLETE)

Have you ever had or been treated for any of the following: (Please attempt to answer every question. If you are unable to answer any of the questions, leave blank and discuss with the nurse or the physician). Underline those areas applicable to your "YES" answer and explain in the comments section indicating which Yes question you are explaining:

1. Severe headaches, migraines, dizzy spells, fainting spells, epilepsy, convulsions, tremors, in coordination? Yes No
2. Any type of mental or nervous trouble, depression, temper problems, suicidal thoughts or attempts? Yes No
3. Injury, pain, whiplash, lumps or goiter of the neck? Yes No
4. Loss of sight, blurred vision, double vision, glaucoma, color blindness, or other disease of the eyes? Yes No
5. Partial or total loss of hearing, ringing of the ears or other disease or condition of the ears of hearing? Yes No
6. Chest pain, disease of the heart, arteries, veins, heart murmurs or rhythm irregularity? Yes No
7. High blood pressure? Yes No
8. Asthma, bronchitis, bronchostenosis, tuberculosis, emphysema, shortness of breath, coughing or spitting of blood? Yes No
9. Disease or disorder of the esophagus, stomach, intestines, or liver, ulcers, colitis, protracted diarrhea, jaundice, hernia or rupture? Yes No
10. Disease or disorder of the kidneys, kidney stones, frequent urination, blood, pus, sugar, albumin in the urine? Yes No
11. Disease or disorder of the prostate, bladder, male/female organs, venereal disease? Yes No
12. Diabetes, high cholesterol, or triglycerdes? Yes No
13. Disease or deformity of the bones, muscles or joints, rheumatism, arthritis? Yes No
14. Broken bones? Yes No
15. Swelling of the face, hands, legs or feet? Yes No
16. Bleeding tendency, easy bruising, anemia, leukemia, or other disease of the blood or glands? Yes No
17. Tumor, growth, cyst, cancer? Yes No
18. Skin condition or disease? Yes No
19. Hay fever or asthma? Yes No
20. Are you allergic to any medication? Yes No
21. Have you ever had a serious allergic reaction of any type? Yes No
22. Do you take more than two (2) alcoholic drinks per day? Yes No
23. Have you had any other serious illnesses in the past? Yes No
24. Have you had any surgical operations? Yes No
25. Have you had abnormal x-ray, electrocardiogram or other laboratory tests within the past five (5) years? Yes No
26. Are you right handed _____ Left-handed _____?

27. In your former employment were you ever exposed to:
- | | | | | |
|----------------------|--------------------------|-----|--------------------------|----|
| Lead | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Extreme Noise | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Radiation | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Dust-metal particles | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Asbestos | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Chemical Fumes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

If yes, explain on page 3 in comments section.

Name: _____

Title: _____

28. Family History

	Heart Disease	Strokes	Cancer	Diabetes	Tuber- culosis	Epilepsy	Mental Illness	High Blood Pressure	Thyroid Disease	Circulatory Problems	Living	Deceased
Relation Mother												
Father												
# Brothers												
# Sisters												
# Children												

29. IMMUNIZATIONS ___ Polio ___ Tetanus ___ Smallpox ___ Diphtheria ___ None ___ Not known.

Part II: (APPLICATION TO COMPLETE) Please answer all questions and explain under comments on page 3. Indicate number of question with an explanation.

- A. Have you ever-received benefits from Workers' Compensation due to an injury? ___ Yes ___ No
- B. Do you have any Workers' Compensation claims pending at this time? ___ Yes ___ No
- C. Have you been in military services? ___ Yes ___ No
 If yes, were you stationed? Overseas: _____
 In the U.S.: _____
- D. Have you ever been rejected or limited for military service? ___ Yes ___ No
- E. Did you receive a medical discharge or disability discharge from the military? ___ Yes ___ No
- F. Did you receive any disability or are you now receiving any disability payments from the Veterans Administration? ___ Yes ___ No
- G. Have you any present-day complaints in relation to your health? ___ Yes ___ No
- H. Have you ever been examined for employment by this company prior to today? ___ Yes ___ No
- I. Do you have any condition which may require special assignment? ___ Yes ___ No
- J. Have you ever strained or injured you back? ___ Yes ___ No
- K. Have you ever been rejected for any type of work due to a back injury? ___ Yes ___ No
- L. Have you ever had prolonged pain or stiffness in the back? ___ Yes ___ No
- M. Have you a back complaint present? ___ Yes ___ No
- N. Have you ever been given light and/or restricted work because of a back injury? ___ Yes ___ No
- O. Have you ever had a back, neck, shoulder, knee or other injury due to an auto accident or other personal or work related injury? ___ Yes ___ No
- P. List any and all drugs and medicines you are currently taking or have used within the past 30 days:

In the event you have any medical problems and or limitations at this time you will need to provide us with medical documentation from the physician(s) that area treating you.

