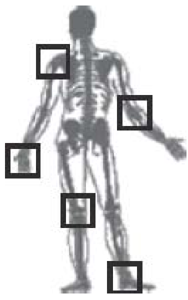

Alexander Raskin, M.D., Q.M.E.
Assistant Clinical Professor UCLA School of Medicine
ORTHOPEDIC SURGERY • SPORTS MEDICINE
ARTHROSCOPY
16311 Ventura Blvd., Suite 1150, Encino, CA 91436
T (818) 788-ORTHO (6784) • F (818) 788-6785

PATIENT INFORMATION SHEET

Date: _______________ **Account No.:** __________________

Section I; Patient Information

☐ **New Patient** ☐ **Old Patient New Problem (Complete Section III)** ☐ **Change of Address (Complete Section I)**
☐ **Change of Insurance Complete Section V (a) (b) (c) (d)** ☐ **Other;** ____________________________________

Patient Name (Last Name, First Name, Middle Initial)	Date of birth:	Age:	Sex:	Marital Status:
Address:	City:	State:	Zip Code:	Home Phone:
Employer Name:	Occupation:			Work Phone Number:
Employer Address:				Cell Phone Number:
Social Security Number:	Driver's License:	Expiration Date:	E-mail Address:	
Spouse's Name:	Spouse's Occupation:			
School Name: * if a student age 18 – 25	Semester and year / Units		Expected date of Graduation:	

Section II: Referring Entity

Referred by: ☐ **Physician** ☐ **Primary Care Physician** ☐ **Yellow Pages** ☐ **The Internet** ☐ **Friend / Relative**
☐**Other:** ____ ***If Other, please describe**

Referring Physician Name:	Address:	Phone Number:
Primary Care Physician:	Address:	Phone Number:
Pharmacy:	Address:	Phone Number:

Section III: Reason for today's visit:

Please indicate body part seen today: (Right / Left):	Date onset of symptom or injury / accident:

Please indicate if the injury / accident was related to:
☐ Auto Accident ☐ Sports Related ☐ Work Related ☐ Other: ______________________________ *if other, please describe

* If auto accident:, please check off what applies ☐ Auto ☐ Motorcycle ☐ Scooter ☐ Off road Motorcycle ☐ Off Road Vehicle ☐ Other: ________________________________	Please describe your role in the accident? ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other: ___________________________________

Please describe injury / accident happen:

Where did the injury / accident occur (Give the location):

Are you seeing an attorney for this injury / accident? ☐ Yes ☐ No
Have you filed a claim with your employer, auto insurance, homeowners policy, or other liability carrier for this injury / accident?
☐ Yes ☐ No
Are you going to file a claim with your employer, auto insurance, homeowners policy, or liability carrier for this injury / accident?
☐ Yes ☐ No

- If you answered yes to any of the above, please complete the information below.

Name of Workers Compensation Carrier, auto insurance, third party liability and/or Attorney	Policy No.	Claim No.

Address:	City:	State:	Zip Code:
Contact Person and or Claim Adjuster:		Phone Number:	

Section IV: Emergency Contact				
Name: (Last Name, First Name, Middle Initial)			Relationship to Patient:	
Address:	City:	State:	Zip Code:	Home Phone:
Section V: Guarantor Information				
Guarantor Name: (Last Name, First Name, Middle Initial)	Date of Birth:		Relationship to Patient:	
Address:	City:	State:	Zip Code:	Phone Number:
Social Security Number:	Driver's License No.:		Expiration Date:	
Employer:			Occupation:	
Address:	City:	State:	Zip Code:	Phone Number:
Section VI (a): Section Medicare / Railroad Medicare				
Name: (Last Name, First Name, Middle Initial)	Date of Birth:		Relationship to Patient:	
Health Insurance Claim No.	Medical Effective Date:		Hospital Effective Date:	
Section VI (b): Medi-Cal / Medicaid				
Name: (Last Name, First Name, Middle Initial)	Date of Birth:		Relationship to Patient:	
Subscriber ID:			Issue Date:	
Section VI (c): Primary Insurance:				
Subscriber Name: (Last Name, First Name, Middle Initial)	Date of Birth:		Relationship to Patient:	
Insurance Plan Name:	Insurance Phone Number:		Effective Date:	
Insurance Plan Address:	City		State	Zip Code:
Social Security No. / Identification No. / Member No.	Policy / Group No.		Employer Group Name:	
Section VI (d): Secondary Insurance:				
Subscriber Name: (Last Name, First Name, Middle Initial)	Date of Birth:		Relationship to Patient:	
Insurance Plan Name:	Insurance Phone Number:		Effective Date:	
Insurance Plan Address:	City		State	Zip Code:
Social Security No. / Identification No. / Member No.	Policy / Group No.		Employer Group Name:	

I certify that the information on this form is true to the best of my knowledge and that I will notify your office of any changes.

______________________________ Signature of Patient and or Legal Representative

______________________________ Relationship to Patient

______________________________ Print Name

______________________________ Date