Registration Sheet

9834 Genesee Ave, Suite 228 La Jolla, CA 92037 • 955 Lane Ave, Suite 200 Chula Vista, CA 91914
1763 West 24th Street, Suite 105 Yuma, AZ 85364

PATIENT INFORMATION

Name: _____ _____ _____ _____/ _____/ _____ _____ Gender: M/ F
Last First M Date of Birth Age

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Address: _____ City: _____ Zip: _____

Phone: Home ( ) _____Cell ( ) _____

Social Security Number: _____-_____-_____ Email: _____

Primary/Referring Physician: _____

Current Employer: _____ Occupation: _____ Phone: ( ) _____

Work Address: _____

Pharmacy: _____ Phone: ( ) _____

SPOUSE/PARENT OR EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: ( ) _____

WORKER'S COMPENSATION INFORMATION

Date of Injury: _____/_____/_____ Employer at the time of injury: _____

Workers' Comp Carrier: _____ Claim Number: _____

Claims Mailing Address: _____ City: _____ Zip: _____

Adjuster Name: _____ Phone: ( ) _____

Fax Number: ( ) _____ Email: _____

Case Manager Name: _____ Phone: ( ) _____

Fax Number: ( ) _____ Email: _____

Attorney: _____ Phone: ( ) _____ Fax: ( ) _____
Area (s) to be examined by (body parts injured): _____

OFFICE USE ONLY

_____ _____
_____ _____

I hereby certify that the above information is correct and accurate to the best of my knowledge. I understand that Synergy Specialist Medical Group will assist me in obtaining benefit verification and authorizations as required; I also understand that this does not guarantee payment from my insurance company. I also authorize Synergy Specialist Medical Group to submit claims on my behalf and obtain any and all records they determine necessary for my treatment and to obtain payment. In the event that Synergy Specialist Medical Group is unable to collect any portion of my bill from my Insurance company, I will be personally responsible for any and all charges and balances allowed by law. I also assign to Synergy Specialist Medical Group any and all insurance benefits and ask that payment for services rendered to me will be made payable and directed to Synergy Specialist Medical Group.

* Authorization to release information: I hereby authorize the release of any medical or other information to my insurance company to process claims for services rendered.
* HIPPA Policy: I hereby acknowledge that I have been offered the Notice of Privacy Practice of Synergy Medical Group.
* Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

_____ _____ _____/ _____/ _____
Patient Signature Print Name Todays date

John H. Serocki, M.D.

Patient Name: _____ Today's Date _____

Age: _____ Height: _____ Weight: _____ Dominant Hand: Right Left

Occupation: _____ Employer: _____

What symptoms are you experiencing (What Hurts)?

_____

_____

How did you get injured or what caused these symptoms?

_____

_____

Have you had any treatment for these symptoms?

(If yes, please list name of facility or physician)

_____

_____

Have you had any recent imaging done? □ Yes □ No

□ X-Ray □ MRI □ Ultrasound □ CT scan □ Other

Where? _____ When? _____

Do you have any allergies to Medication/Substance? □ Yes □ No □ I Don't Know

(If yes, please list)

Medication/Substance: _____ Reaction: _____

Medication/Substance: _____ Reaction: _____

Are you taking Medication? □ Yes □ No

Medication: _____ Dose: _____ Used for: _____ How Often _____

Medication: _____ Dose: _____ Used for: _____ How Often _____

Medication: _____ Dose: _____ Used for: _____ How Often _____

List any surgeries or hospitalizations, including date(s) done.

Surgery _____ Date _____ Work Related? Y N

Surgery _____ Date _____ Work Related? Y N

Surgery _____ Date _____ Work Related? Y N

Have you used any of the following substances: Circle No or Yes and fill in the blanks.

SUBSTANCE	CURRENTLY USE	PREVIUOSLY USED	HOW OFTEN	HOW LONG	IF STOPPED, WHEN
Caffeine: coffee, tea, soda	**NO YES**	**NO YES**			
Tobacco	**NO YES**	**NO YES**			
Alcohol: beer, wine	**NO YES**	**NO YES**			
Recreation/Street Drugs	**NO YES**	**NO YES**			

Circle any medical condition(s) that you currently have or have had previously:

Heart Attack	**Stroke**	**Cardiac Stent**	**Cardiac Condition**	**Heart Disease**
High Blood Pressure	**Diabetes**	**High Cholesterol**	**Thyroid Disease**	**Thyroid Disease**
Liver Disease	**Gastritis or Ulcers**	**Polio**	**Tuberculosis**	**Thyroid Condition**
Fibromyalgia	**Hepatitis A, B, C**	**Rheumatoid Arthritis**	**Gout**	**Blood Clots**
Anemia	**Osteoarthritis**	**Emphysema**	**Epilepsy**	**Enlarged Prostate**
Asthma	**Sleep Apnea**	**Neurological Disease**	**Recurrent Headaches**	**Recent Weight Loss**
Constant Night Pain	**Fever or Chills**	**Depression**	**HIV/AIDS**	**Drug Abuse**

Please list any medical condition not listed above:

_____

_____

Family Medical History:

Please list any medical condition(s) that run in your family medical history:

_____

_____

_____

Please list any leisure activities, including sports or athletic, that you participate in:

_____

_____

_____

****

Medical use only

John H. Serocki, M.D.

INDUSTRIAL MEDICINE QUESTIONAIRE

Patient Name: _____ Date: _____

Name of employer at the time of injury: _____

Address: _____

Type of business: _____

Date of Injury: _____ Time injury occurred: _____ (am/pm)

Date employer notified: _____

Date last worked: _____ Are you on light duty? □ No □ Yes

Date you stated Light Duty: _____

Are you still employed by the same employer: □ No □ Yes

Date you separated: _____

Are you back to regular duty? □ No □ Yes Date you started _____

Affected body part: □ Right □ Left
(ex. Knee, shoulder, elbow, back, etc.)

_____

_____

Have you ever injured the affected area(s) in the past? □ No □ Yes
If yes, please explain

_____

_____

Please describe you work duties

_____

_____

_____

If you have a back injury, are you also experiencing pain in your legs? □ No □ Yes

If yes, how would you divide your pain between the two, please circle only one pair of numbers below.

Note: Back pain is pain located above the belt line. Leg pain is pain located below the belt line, including the hips and buttocks.

BACK	**100%**	**90%**	**80%**	**70%**	**60%**	**50%**	**40%**	**30%**	**20%**	**10%**	**0%**
LEGS	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**

If you have a neck injury, are you also experiencing pain in your arms? □ No □ Yes

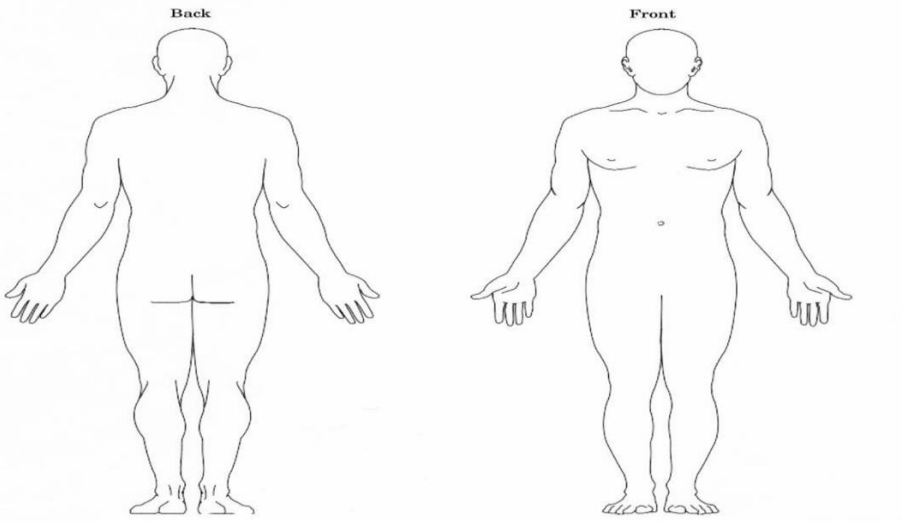
If yes – how would you divide your pain between the two, please circle only one pair of numbers below.

Note: Arm pain includes the shoulders all the way to the tips of the fingers.

NECK	**100%**	**90%**	**80%**	**70%**	**60%**	**50%**	**40%**	**30%**	**20%**	**10%**	**0%**
ARMS	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**

Mark the areas on your body where you feel the described sensations. Include all affected area. Use the appropriate symbol.

Ache	Numbness	Pins and Needles	Burning	Stabbing
^^^^^^	- - - - -	oooooo	xxxxx	//////



Patient: _____ DOB: _____/____/_____

Signature: _____ Date: _____

John H. Serocki, M.D.

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

☐ **I give Permission for my physician/staff to speak with the following family member or significant other regarding confidential health information, only when medically necessary, or in my best interest:**

Name: _____

Name: _____

☐ **Phone**

I want you to contact me by telephone at _____

☐ Do ☐ Do not leave messages on my answering machine.

☐ Do ☐ Do not leave messages with any other person.

☐ **Mail**

I want you to contact me at the following address _____

_____

☐ **E-mail**

I want you to contact me at the following e-mail address: _____

☐ **Fax**

I want you to contact me at the following fax number: _____

☐ **Other** _____

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate:

Relationship:
- ☐ Parent or guardian of minor patient
- ☐ Guardian of conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

Name of patient: _____

****

For office use only:

Date Granted: _____

Date Terminated of Modified: _____