# ORTHOPEDIC MEDICAL GROUP OF SAN DIEGO, INC.

___ Richard F. Santore, M.D.
___ Michael P. Muldoon, M.D.
___ Rina Jain, M.D.

3750 Convoy Street Suite 201
San Diego, CA. 92111
(858) 278-8300
(858) 278-1708

___ Update _____
___ New Info _____
___ New Injury _____

**For Office Use Only**

## REGISTRATION INFORMATION
## WORK COMP / MED-LEGAL

(_) AME (_) IME (_) QME (_) WORK COMP (_) AOE-COE Date: _____

Patient's Full Name: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:(____)_____ Work Phone: (____) _____

Mobile:(____)_____ E-Mail: _____

Marital Status: _____ Date Of Birth: _____ Age: _____ Sex: _____ Social Security #: _____

Billing Address: (if other than above): _____ City: _____ State:_____ Zip: _____

Current Employer: _____ Occupation: _____

Address: _____ City: _____ State:_____ Zip: _____

Referred By: _____ Part of the body affected: _____ Right ( ) Left ( )

How long have you had the symptoms? _____ Date last worked: _____

Did your symptoms follow an injury? _____ How did it occur? _____

Where did it occur? ( ) On the job ( ) Home ( ) Auto ( ) Other _____ Date of Injury:_____Hour: _____

Work Comp Carrier: _____

Address: _____ City: _____ State: _____ Zip: _____

Claims Examiner: _____ Claim #:_____

Telephone: _____ Fax: _____

Employer at time of the injury: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Private Party Responsibility: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip: _____

Plaintiff's Attorney: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Defense Attorney: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Friend / Relative in the area: _____ Telephone: _____

Have you ever been seen in this office before? Yes ( ) No ( ) By: _____

I hereby authorize Orthopedic Medical Group of San Diego, Inc. to furnish to my insurance company, a designated attorney, ancillary services providers, and or their representatives, medical and financial information which they may require to provide services or process a claim.

Patient's / Guardian's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

# Acknowledgement of Receipt of Notice of Privacy Practices

Orthopedic Medical Group of San Diego, Inc. and all Affiliated Physicians

3750 Convoy Street, Suite 201

San Diego, CA 92111

Privacy Officer: Office Manager (858) 278-8300

I hereby acknowledge that I received a copy of Orthopedic Medical Group of San Diego, Inc. and all Affiliated Physicians Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

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

Name of Patient: _____