Scott P. Leary, M.D.

Patient Registration Sheet

Referring Physician: _____

Address: _____

City, State, Zip: _____

Telephone :( )_____

Patient Name: _____
(First, Last)

Home Address: _____
(City, State, Zip)

Home Phone: ( ) _____ **Work Phone: ( )** _____

Cell No. / Pager :( ) _____ **Fax#: ( )** _____

Date of Birth: _____ / _____ / _____ **SSN#** _____ - _____ - _____ **Sex: ◊ Male ◊ Female**

Marital Status: ◊ Married ◊ Single ◊ Widowed ◊ Divorced

Email Address: _____**Occupation:**_____

Employer Name: _____

Employer Address:_____
(City, State, Zip)

Emergency Contact: _____ **Relationship** _____

Emergency Contact Telephone# :( ) _____

Complaint: _____

Medicare Number: _____**Part A**_____ **Part B** _____**Effective Date**_____

Primary Insurance: _____ **◊ PPO ◊ POS**

Insurance Address: _____

Insurance Telephone: _____ **Group#:** _____ **ID#:**_____

Effective Date: _____/_____/_____**Coverage Code:** _____ **Subscriber Name:**_____

Policyholder (if patient is NOT the subscriber) DOB: _____/_____/_____ **SSN#:** _____ -_____ -_____

Secondary Insurance: _____**◊ PPO ◊ POS**

Insurance Address: _____

Insurance Telephone: _____ **Group#:** _____ **ID#:**_____

Effective Date: _____/_____/_____ **Coverage Code:** _____**Subscriber Name:** _____

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Patient Registration Sheet

WORKERS COMPENSATION INFORMATION (IF APPLICABLE)

Name of Insurance Company: _____

Address: _____

City, State, Zip Code: _____

Name of Adjuster: _____

Telephone Number: _____ext _____Fax Number: _____

Nurse Case Manager: _____

Telephone Number: _____ext_____ Fax Number: _____

Claim Number: _____ Date of Injury: _____

Employer: _____

WCAB Number: _____

OFFICE USE ONLY

New Patient Packet Received on _____

Reviewed by RN on: _____ OK to schedule: _____Other: _____

Appointment Date/Time: _____

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Personal

Name	**Last First Middle**
Age	**Sex Occupation Working/Disabled/Retired Rt. or Lft. Handed**
Marital Status	**□ Married □ Single □ Divorced □ Separated □ Widowed**

Current Problems:

Symptoms:	Duration:

Past Medical History

Previous Operations:	**Dates:**

Other Past and Current Medical Problems:
(eg. Hypertension, diabetes, asthma, stroke, cancer, etc)

Family History: Parents, grandparents, siblings (alive, if deceased, list cause)

Medications:

Medications: (List all current medications: (including aspirin)

Allergies to medication:

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Patient Registration Sheet

Functional Questionnaire

Name: _____ Date: _____

How long have you had back/neck pain? _____ Years _____ Months _____ Weeks

How long have you had leg/arm pain? _____ Years _____ Months _____ Weeks

Please read:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the ***one box*** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just ***mark the box which most closely describes your problem.***

Section I – Pain Intensity

□ I can tolerate the pain I have without having to use painkillers
□ The pain is bad, but I can manage without taking painkillers
□ Pain killers give me complete relief from pain
□ Pain killers give very little relief from pain
□ Pain killers have no effect on the pain and I do not use them

Section 2 – Personal Care (Washing, Dressing, Etc)

□ I can look after myself normally without causing extra pain
□ I can look after myself normally, but it causes extra pain.
□ It is painful to look after myself, and I am slow and careful
□ I need some help, but manage most of my personal care
□ I need help everyday in most aspects of self care
□ I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting

□ I can lift heavy weights without extra pain
□ I can lift heavy weights but it gives me extra pain
□ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, ie on the table
□ Pain prevents me from lifting heavy weights but I can manage Light to medium weights if they are conveniently positioned
□ I can only lift very little weights
□ I cannot lift or carry anything at all

Section – 4 Walking

□ Pain does not prevent me from walking any distance
□ Pain prevents me from walking more than 1 mile
□ Pain prevents me from walking more than ½ mile
□ Pain prevents me from walking more than ¼ mile
□ Pain prevents me from walking more than 10 min.
□ Pain prevents me from walking at all

Section 5 – Sitting

□ I can sit in my chair as long as I like
□ I can only sit in my favorite chair as long as I like
□ Pain prevents me from sitting more than ½ hour
□ Pain prevents me from sitting more than 10 mins
□ Pain prevents me from sitting at all

Section 6 – Standing

□ I can stand as long as I want without extra pain
□ I can stand as long as I want, but it gives me extra pain
□ Pain prevents me from standing for more than one hour
□ Pain prevents me from standing for more than 30 mins
□ Pain prevents me from standing for more than 10 mins.
□ Pain prevents me from standing at all

Section 7 – Sleeping

□ Pain does not prevent me from sleeping well
□ I can sleep well only by using tablets
□ Even when I take tablets I have less than six hours sleep
□ Even when I take tablets I have less than four hours of sleep
□ Even when I take tablets I have less than two hours of sleep
□ Pain prevents me from sleeping at all

Section 8 – Sex Life

□ My sex life is normal and gives me no extra pain at all
□ My sex life is normal but increases the degree of pain
□ My sex life is nearly normal but it very painful
□ My sex life is nearly absent because of pain
□ Pain prevents any sex life at all

Section 9 – Social Life

□ My social life is normal and gives me no extra pain
□ My social life is normal but increases the degree of pain
□ Pain has no significant effect on my social life apart from limiting my more energetic interests, ie dancing etc.
□ Pain has restricted my social life and I do not go out as often
□ Pain has restricted my social life to home
□ I have no social life because of pain

Section 10 –Traveling

□ I can travel anywhere without extra pain
□ I can travel anywhere but it gives me extra pain
□ Pain is bad bit I manage journeys over two hours
□ Pain restricts me to journeys of less than one hour
□ Pain restricts me to short necessary journeys under 30 mins
□ Pain prevents me from traveling except to the doctor or hospital

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Patient Registration Sheet

General Review of Systems
Provided to Scott P. Leary, MD

Name:_____
Signature:_____

Allergies
○ Asthma
○ Hay Fever
○ Skin eruptions

Cardiovascular
○ Chest pain
○ Irregular heart beat
○ High/low blood pressure
○ Poor circulation
○ Rapid heart rate
○ Swelling of ankles
○ Varicose veins

Constitutional
○ Chills/sweats/fever
○ Fainting
○ Forgetfulness
○ Heachache
○ Loss of sleep
○ Nervousness
○ Weight loss

Ears, Nose, Mouth, Throat
○ Bleeding gums
○ Difficulty swallowing
○ Earache
○ Ear discharge
○ Hearing loss
○ Hoarseness
○ Nosebleeds
○ Persistent cough
○ Ringing in ears
○ Sinus problem

Endocrine
○ Rapid Weight loss/gain
○ Intolerance to warm room
○ Multiple broken bones
○ Cessation of menstrual periods
○ Excessive hunger/thirst
○ Loss of libido
○ Spontaneous nipple discharge

Eyes
○ Blurred Vision
○ Crossed eyes
○ Double vision
○ Vision flashes or halos

Genitourinary
○ Blood in urine
○ Lack of bladder control
○ Painful urination

Gastrointestinal
○ Bloating
○ Bowel changes
○ Constipation
○ Diarrhea
○ Gas
○ Hemorrhoids
○ Indigestion
○ Nausea
○ Poor appetite
○ Rectal bleeding
○ Stomach pain

Hematologic/Lympathic
○ Swollen lymph nodes
○ Easy bruising skin
○ Prolonged bleeding from cuts, tooth extractions

Integumentary
○ Skin rashes or eruptions
○ Chronic skin itching

Men
○ Breast lump
○ Lump in testicle
○ Penis discharge
○ Sore on penis

Musculosketal
Pain, weakness, numbness or swelling in:
○ Hands, wrists, hips, knees, or joints
○ Pain in arms or legs

Neurological
○ Fainting
○ Headaches
○ Numbness of arms or legs
○ Seizures
○ Tingling of hands, feet, arms, or legs

Psychiatric
○ Anxiety
○ Depression
○ Panic attacks
○ Restlessness

Respiratory
○ Blood
○ Cough
○ Dizziness
○ Shortness of breath

Women
○ Abnormal pap smear
○ Bleeding between periods
○ Breast lump
○ Extreme menstrual pain
○ Hot flashes
○ Nipple discharge
○ Painful intercourse

Date of last period:_____
Date of last pap smear:_____
_____

Mammogram Date: _____
_____

Are you pregnant? _____
No. of children (ages) _____
_____
_____
_____
_____
_____

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Patient Registration Sheet

PATIENT: _____ **AGE:**_____ **DATE:** _____

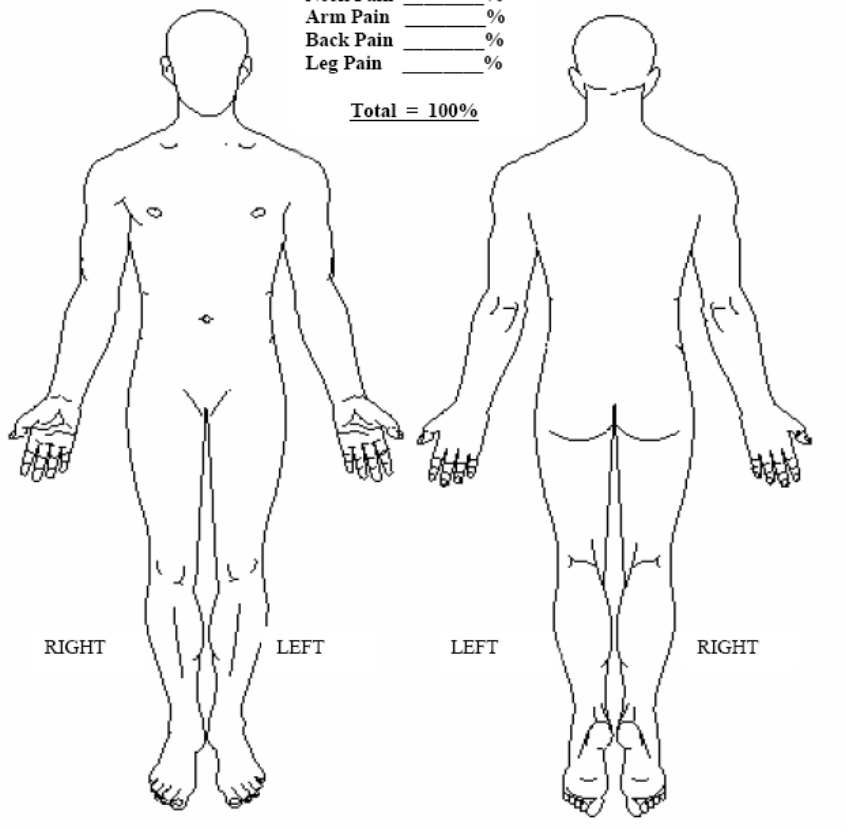
WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	RADIATING PAIN
^ ^ ^	O O O	■ ■ ■	X X X	/ / /
^ ^ ^	O O O	■ ■ ■	X X X	/ / /
^ ^ ^	O O O	■ ■ ■	X X X	/ / /

Neck Pain _____%
Arm Pain _____%
Back Pain _____%
Leg Pain _____%

Total = 100%



PLEASE MARK ON THE LINE:

How bad is your pain now?

❶_____❷_____❸_____❹_____❺_____❻_____❼_____❽_____❾_____❿

NO PAIN **INTERMEDIATE PAIN** **WORST PAIN**

Scott P. Leary, M.D.
Patient Registration Sheet

Scott P. Leary, M.D.
9850 Genesee Avenue, Suite #650
La Jolla, CA 92037
858-750-1670 (Office)
858-750-1437 (Fax)
www.scottlearymd.com

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. of foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs

Scott P. Leary, M.D.

Patient Registration Sheet

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. You can request a restriction in our use or disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family member and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
2. You have the right to request and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to John J Regan, M.D., 120 S. Spalding Drive, Suite 400, Beverly Hills, CA. 90212 Telephone : 310-385-8010
3. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is by or for our practice. To request an amendment, your request must be made in writing and submitted to John J Regan, M.D., 120 S. Spalding Drive, Suite 400, Beverly Hills, CA. 90212, Telephone : 310-385-8010 You must provide us with a reason that supports your request for amendment.
4. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice, contact our front desk receptionist.
5. Right to file a complaint. If you believe your privacy right has been violated, you may file a complaint with out practice of with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact John J Regan, M.D., 120 S. Spalding Drive, Suite 400, Beverly Hills, CA. 90212 Telephone : 310-385-8010. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any regarding this notice or our health information privacy policies, please contact:

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I, _____
have read and received the HIPAA notice of Privacy Practices.

Signature

Print Name

Date: _____

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Patient Registration Sheet

Please list any medications you have allergies to :

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list doctors you want reports sent to:

Doctor _____ **Practice** _____

Phone Number _____ **Fax Number** _____

Address _____ **Suite** _____

_____

_____

Full Name _____

Date of Birth _____ / _____ / _____

Social Security _____ - _____ - _____

Confidential Phone number ( ) _____