STEVEN J. WALTRIP, M.D.
A Medical Corporation

PATIENT INFORMATION: (Please Print in black ink ONLY)

Name:____
Date of Birth:____________________ Sex: Male Female Marital Status: M/S/D/W
Driver's License #:____________________ S.S.#____________________
Address:____
City:______________________________ State:________ Zip:____________
Home Phone:____________________ Work/Cell:____________________
Employer:____________________ Occupation:____________________
Spouse's Name:____________________ Work#:____________________
Referred By:____

IN CASE OF EMERGENCY:

Name:____________________ Relationship:____________________
Phone:____________________

PERSON FINANCIALLY RESPONSIBLE: (Fill out only if different from patient)

Name:____
Address:____
City:______________________________ State:________ Zip:____________
Home Phone:____________________ Work#:____________________
Employer:____________________ Occupation:____________________
Driver's License #:____________________ S.S. #:____________________

INSURANCE INFORMATION:

Primary Insurance Company:____________________ Phone#:____________________
Policy Holder:____________________ Relationship to Patient:____________________
Policy #:____________________ Group#:____________________

Secondary Insurance Company:____________________ Phone#:____________________
Policy Holder:____________________ Relationship to Patient:____________________
Policy #:____________________ Group#:____________________

WORKER'S COMPENSATION INFORMATION:

Insurance Company:____________________ Claim#:____________________
Address:____
City:______________________________ State:________ Zip:____________
Adjuster:____________________ Phone:____________________
Fax#:____________________

I certify that the information provided is true and accurate to the best of my knowledge.

Signature:____ Date:____________

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ASSIGNMENT OF BENEFITS

I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the insurance policy, I will be responsible to the Doctor for payment of the entire bill.

Patient Signature Date

I authorize the release of any medical information to my insurance carrier as requested. I permit a copy of this authorization to be used in place of the original.

Patient Signature Date

Medicare Patients Only:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment (Section 1128b of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.) Regulations pertaining to Medicare Assignment of benefits also apply.

Medicare Recipient Signature Date

465 North Roxbury Drive, Suite 750
Beverly Hills, Ca 90210
Telephone: 310.860.3434 Facsimile: 310.860.3456

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CANCELLATION POLICY

Due to the demand of our business and in fairness to other patients, we find it necessary to require a minimum of **24 hour** notice during our business hours of 8 a.m. to 5 p.m. for cancellation and/or re-scheduling of your appointment.

All appointments not canceled 24 hours in advance will be charged **$75.00.**

Thank you for your cooperation.

Signature:______________________________ Date:________________

465 North Roxbury Drive, Suite 750
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Steven J. Waltrip, M.D.
A Medical Coporation

MEDICAL HISTORY

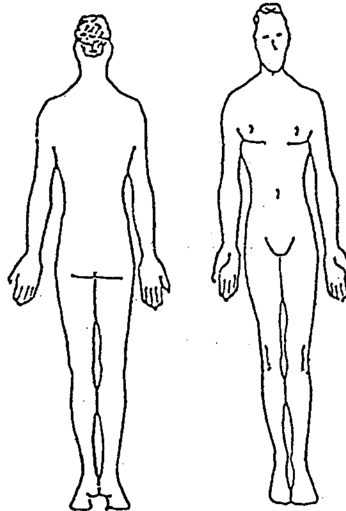
Name:____________________________Date:__________Age:______
Referred By:____________________Occupation:________________
INTERNIST: ______________

1. DO YOU HAVE ANY ALLERGIES TO MEDICATION?

____

2. MARK THE AREAS ON YOUR BODY WHERE YOU FEEL PAIN/NUMBNESS/OR TINGLING: 0% BEING LESS AND 100% BEING GREATER

NECK/BACK____%



ARM/LEG____%

3. DATE OF ONSET____________________

ARE YOU GETTING: WORSE BETTER STABLE

4. PLEASE DESCRIBE ALL PRESENT

PAIN:____

BODY PARTS AFFECTED:______________________________

TYPE OF PAIN:______________________________________

____

PAIN RADIATION (DESCRIBE):__________________________

____

5. PAIN RATING: PLEASE CIRCLE THE DEGREE OF PAIN YOU ARE CURRENTLY EXPERIENCING:

0	1	2	3
NO PAIN	MILD	MODERATE	SEVERE

6. DO YOU HAVE ANY PAIN NUMBNESS OR TINGLING IN YOUR ARM/LEG?

____

7. WHAT POSITION AND/OR MEDICATION RELIEVES YOUR PAIN?

____

____

8. DESCRIBE YOUR INJURY & HOW YOUR SYMPTOMS BEGAN IN DETAIL:

____

____

____

9. REPORT ANY PREVIOUS INJURIES:______________________________

____

10. HAVE YOU HAD ANY PRIOR SURGERY IN THE AFFECTED AREA?

____

____

11. ARE YOU PRESENTLY WORKING:
FULL TIME____ PART TIME____ NOT WORKING____ TOTAL DISABILITY____ PARTIAL DISABILITY____

12. IF YOU ARE ON TOTAL OR PARTIAL DISABILITY WHEN DID IT BEGIN?

____

13. ANY WORK RESTRICTIONS OR MODIFICATION? PLEASE DESCRIBE:

____

____

14. HAVE YOU HAD ANY TREATMENT/THERAPY OR TEST SUCH AS X-RAY, MRI, EPIDURAL, ETC. RELATED TO YOUR PROBLEM. IF SO PLEASE DESCRIBE.

TEST/STUDY:	DATE:	RESULT:
____________	__________	______________________
____________	__________	______________________

15. HAVE YOU TRIED HOME TREATMENT OR MEDICATION?
PLEASE DESCRIBE:______________________________

____

16. WHAT TREATMENT/S HAVE YOU RECEIVED?

PHYSICAL THERAPY BRACING HOME EXERCISES

CHIROPRACTIC EPIDURALS ACCUPUNCTURE

PILATES SURGERY

17. HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING
(PLEASE CIRCLE ALL THAT APPLY)

FATIGUE FAINTNG MEMORY LOSS

DEPRESSION STRESS LOSS OF CONCENTRATION

HEARTBURN DIFFICULTY VOIDING

(17. CONTINUED)

SHORTNESS OF BREATH   SLEEP DIFFICULTY

WEAKNESS   ITCHING   HEADACHES   NUMBNESS

TINGLING   NERVOUSNESS   NAUSEA   ULCERS

LOSS OF APPETITE/ VOMITING   URINARY INCONTINENCE/ BOWEL PROBLEMS

EARLY AWAKENING   FACIAL PAIN   HEARING DIFFICULTY

OTHER (PLEASE DESCRIBE)______________________________________

18. IF YOU ARE FEMALE, ARE YOU PREGNANT?______________________________

19. PAST MEDICAL HISTORY, PLEASE CIRCLE ANY OF THE FOLLOWING:

URINARY PROBLEMS   HEART DISEASE

EAR, EYE, OR NOSE PROBLEMS   CIRCULATORY/CVA

RESPIRATORY PROBLEMS: ASTHMA/HAYFEVER   ARTHRITIS/GOUT

CANCER   HYPERTENSION   LIVER OR KIDNEY PROBLEMS

DIABETES, HYPOGLYCEMIA   DRUG ABUSE, ALCOHOLISM

GASTROINTESTINAL PROBLEM   DEPRESSION OR PSYCHOLOGICAL

20. PLEASE EXPLAIN ANY OF THE ABOVE______________________________
____

21. CURRENT MEDICAL STATUS:
ARE YOU CURRENTLY RECEIVING TREATMENT FOR ANY OTHER MEDICAL CONDITION?____
____

22. MEDICATIONS: PLEASE LIST ANY & ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND THE DAILY DOSAGE FOR EACH:
____
____

23. FAMILY HISTORY:
IS THERE A HISTORY OF SPINAL PROBLEMS IN YOUR FAMILY:
YES__________ NO__________

24. DO YOU SMOKE: YES________ NO________
DO YOU DRINK ALCOHOL? YES________ NO________
IF YES HOW OFTEN?
____