Melvin H. Nutig, MD
150 N. ROBERTSON BLVD., SUITE 250, BEVERLY HILLS, CA 90211
P: (310) 659-2910 F: (310) 652-2568

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name: First: Middle:			☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth date:	Age:	Social Security Number:	Sex: ☐ M ☐ F
Preferred Language:			Race:		Ethnicity:
Street address:			Cell phone: ( )		Home phone: ( )
City:	State:	ZIP Code:	Driver's License:	Email address:	
Occupation:	Employer & Employer Address:				Employer phone: ( )
Who referred you to this office? (Please check one box):	☐ Referred by Doctor - Dr.'s Name:				
☐ Family – Name:	☐ Friend - Name:	☐ Internet	☐ Hospital – Name:		
How would you like us to contact you for appointment reminder: ☐ Home Phone ☐ Cell Phone					
PHARMACY: Name, address, and phone number of pharmacy you would like medications called in to:					

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Person responsible for bill:	Birth date:	Address (if different):			Home phone: ( )
Is this person a patient here? ☐ Yes ☐ No	Is this injury: ☐ Work Related ☐ Auto ☐ Personal Injury				
Is this patient covered by insurance? ☐ Yes ☐ No					
Please indicate primary insurance	☐ Blue Cross	☐ Blue Shield	☐ Aetna	☐ Cigna	☐ HealthNet
☐ SAG	☐ PacifiCare	☐ Medicare	☐ Medicare / Medi-Cal	☐ Other	
Subscriber's name:	Subscriber's S.S. number:	Birth date:	Group number:	Policy number:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group number:	Policy number:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone: ( )	Work phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Beverly Hills Orthopedic Group or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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HISTORY FORM - NEW PATIENT

PATIENT NAME:_____**TODAY'S DATE**_____

Who referred you to this office? _____ **Internist/Family MD**_____

CHIEF COMPLAINT

1) What is the main reason for your visit today? _____Right / Left /Both

HISTORY OF PRESENT ILLNESS

Age_____ Height_____ Weight_____ Right/Left Handed_____ Occupation_____

1) What was the date your symptoms started/were injured?_____

2) Explain Injury: _____
_____

3) Was this a work related accident? ☐ Yes ☐ No
If yes, are you still working? ☐ Yes ☐ No
If yes, are you working: ☐ Full ☐ Light duty

4) Was this an auto accident? ☐ Yes ☐ No
If so, were you driving? ☐ Yes ☐ No
Did airbags inflate? ☐ Yes ☐ No

5) Recreational or athletic injury? ☐ Yes ☐ No

6) Accident in your home? ☐ Yes ☐ No

7) On a scale of 1 (least) to 10 (greatest), what level is your pain today? 1 2 3 4 5 6 7 8 9 10

8) Describe symptoms you are having (check all that apply):

☐Aching ☐ Gives way ☐ Sharp ☐ Stabbing ☐Wakes you up
☐Clicking ☐ Locking ☐ Snapping ☐ Throbbing ☐ Weakness
☐Dull ☐ Numbness ☐ Sore ☐ Tingling ☐

9) How long does problem last? ☐ Constant ☐ Comes and goes ☐ Other:_____

10) Does anything make it better? ☐ Yes ☐ No Explain:_____
(eg: ice, rest, standing, sitting, meds, etc)

11) Does anything make it worse? ☐ Yes ☐ No Explain:_____
(eg: standing, sitting, bending, lifting, etc)

12) Does it radiate anywhere? ☐ Yes ☐ No If so, where:_____

13) List any other doctors you have seen for this problem:
_____

14) List any previous tests, procedures, treatments (injections, physical therapy, medications) for this problem:
Physical Therapy: _____# of visits per week x _____weeks/months
Injections: How many?_____Date of last injection___/___/_____Type of injection_____
Medications you have tried:_____
Chiropractic/Acupuncture:_____# of visits

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MEDICATIONS

Are you sensitive or allergic to any medications? ☐ Yes ☐ No

If yes, please mark all that apply: ☐ Penicillin ☐ Keflex ☐ Aspirin ☐ Codeine ☐ Tetracycline
☐ Erythromycin ☐ Valium ☐ Demerol ☐ Barbituates ☐ Epinephrine
☐ Iodine ☐ Latex ☐ Naproxen ☐ Other_____

Are you currently taking:
Any cortisone-type medication (e.g. Prednisone)? ☐ Yes ☐ No
Any blood thinning medication (e.g. Coumadin, Warfarin, ASA, Plavix, etc)? ☐ Yes ☐ No
Family member ever had major adverse reaction to anesthesia? ☐ Yes ☐ No
If yes, Explain_____

Please list all the medications you are currently taking and the dosages:
_____
_____
_____
_____

PAST MEDICAL HISTORY

Serious Childhood Illnesses:_____

Adult Illnesses: List and document hospital stays if any_____
_____

Surgeries: List date, procedure, surgeon, and hospital_____
_____

Major accidents/Injuries with dates:_____
_____

FAMILY HISTORY

Father: Age if alive_____ Age/death and cause_____
Mother: Age if alive_____ Age/death and cause_____
Siblings: Age/health status_____
Children: Age/health status_____
Family Disease: (Hypertension, Diabetes, Tuberculosis, Gout, Cancer, etc)_____
_____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how much?_____How long?_____
If no, did you ever smoke? ☐ Yes ☐ No If yes, how much?_____How long?_____Year quit_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____How often?_____

Do you take any drugs? ☐ Yes ☐ No If yes, what drugs?_____
How often?_____
Have you been or are you addicted? _____Detoxed? _____

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REVIEW OF SYSTEMS
Please circle those that apply or check the "none" box

GENERAL
Fever, Night Sweats
Marked Weight gain/loss
None☐

HEAD, EYES, EARS, NOSE
Frequent headaches
Neck pain/stiffness
Glaucoma
Blurring/vision
Dizziness
Hearing problems
Sinus problems
None☐

CHEST/RESPIRATORY
Asthma
Sputum production from cough
Cough up blood
Chronic cough
Positive TB skin test
Abnormal Chest X-ray
None☐

CARDIAC
High Blood Pressure
History of Heart attack
Chest Pain
Rapid/Abnormal Pulse
Ankle Swelling
None☐

VASCULAR
Previous phlebitis
Leg cramps on exercise
Varicose veins
Poor circulation
None☐

GASTROINTESTINAL
Ulcers/gastritis
Severe/frequent abdominal pain
Tarry/Black bowel movements
Yellow/Jaundice
Vomit blood, Hepatitis
None☐

GYNECOLOGICAL/WOMEN
Pregnant now? _____
Abnormal/irregular periods
Date last period_____
Age periods stopped___
None☐

MUSCULOSKELETAL
General joint pain/arthritis
Joint swelling
Spinal pain
None☐

ENDOCRINE
Diabetes
Thyroid abnormality
Gout
Osteoporosis
None☐

NEUROLOGICAL
Fainting
Convulsions
Dizziness
Shakiness/trembling
Diffuse muscle weakness
Tingling in extremities
None☐

URINARY
Kidney Stones
Blood in your urine
Frequent/Painful urination
Recurrent Kidney/Bladder infections
None☐

PSYCHIATRIC
Psychiatric Hospitalization
Depression
Frequent Mood Swings
History of substance abuse
None☐

OTHER
AIDS/HIV
Tested positive for HIV? Yes☐ No☐ When? _____

I attest that the above information is true and correct to the best of my knowledge and recollection.

Signature of Patient or Legal Representative_____**Date**_____