Orange County Medical Group

Dr Alexander Latteri, MD

Workers Comp

Name of Referral Source: Tel:

Address:

Reason for Referral:

Patient Information

Last Name	First Name	Middle Initial	☐Mr ☐Miss ☐Mrs. ☐Ms.	Home #: Cell #:
Birth date: Age	Sex ☐M ☐F	SS#:	Date of accident: Case Description:	☐WC ☐PI ☐PPO ☐Medicare ☐Cash

Street Address:

City State Zip

Attorney Information (Please provide accurate information)

Attorney: Tel:

Address: Fax:

City State Zip Contact:

Employer Information (Please provide accurate information)

Employer Tel:

Address Fax:

City State Zip Occupation

WC Patients Only Insurance Information (Please provide accurate information)

Insurance Carrier Tel:

Address: Fax:

City State Zip Adjuster

Claim #: WCAB #:

ALL OTHER INSURANCE PATIENTS PLEASE PROVIDE INSURANCE CARD

1211 W. La Palma Ave., Suite 709, Anaheim, CA. 92801

Name of Patient _____ Today's Date _____

Height _____ Weight _____ Age _____ Educ. Levl: (ie. HS, College) _____

Date of Injury: _____ Type of Injury: ☐ Work ☐ Auto ☐ Sport ☐ Fall

1. Have you ever been examined at this facility? ☐ Yes ☐ No When? _____

2. Allergies? _____ Current Medications: _____

3. Describe how your injury happened? What activities were you doing when the injury occurred?

_____

4. What parts of the body were injured? _____

Did the pain develop immediately or gradually or both _____

5. When did you report the accident? (ie. Day of injury, days/months later) _____

6. When and where did you first obtain medical care? (ie. date of injury, next day, from company doctor, HMO, private, chiro?)

_____

7. Where did you go for follow up care? (ie. company M.D., chiro, HMO, private) _____

8. Did you receive physical therapy, chiro, acupuncture? Yes ☐ No ☐

How many visits (ie. 10 visits, 2 months) _____

9. What special medical tests were done: (ie. MRI, EMG/NCV, epidural injection, ultrasound) _____

10. How many weeks or months did you take off from work because of the injury? Include dates _____

11. Did any problems develop while under current medical treatment? _____

12. Are you scheduled for evaluation for continued care with another doctor? ☐ Yes ☐ No Names _____

13. Have there been any new injuries since the date of the initial injury? ☐ Yes ☐ No Type _____

14. Are you working now? ☐ Yes ☐ No Type of work? _____

Current income: ☐ W/C payment ☐ SS disability ☐ Welfare ☐ None ☐ Unemployment Other _____

15. Date last worked? _____

Were you fired, placed on disability, laid off, or unable to work because of pain? _____

16. **Any prior injuries:** Date, injured body part, how was the case settled, did you recover? ☐ Yes ☐ No

Any permanent disability award? _____

A. Work injury _____

B. Motor vehicle accident _____

C. Sports or home inj _____

17. **Check any medical problems you have:**

☐ Diabetes	☐ Heart Trouble	☐ Cancer	☐ Asthma	☐ Ulcers
☐ Kidney Problems	☐ High Blood Pressure	☐ Bladder Infection	☐ Pneumonia	☐ GYN Problems
☐ Stroke	☐ Bleeding Tendencies	☐ Depression	☐ Anxiety	
☐ Liver Disease	☐ Psychiatric Problems	☐ Other		

18. **FOR FEMALES ONLY:** Are you pregnant? ☐ Yes ☐ No ☐ Not sure ☐ LMP

Job Description

Employer at the time of injury:

How long did you work for this employer?

Job title at time of injury:

Describe the duties of your job at the time of injury:

If now working: Name of present employer with job title and describe present work activities:

Your major hand is ☐ Right ☐ Left (Check one)

Which of the follow demands are required of your job or to your injury and at the present time? Check ones that apply, and state frequency. “Constant”, “Occasional”, “Frequent”).

ACTIVITY	PRIOR	PRESENT	ACTIVITY	PRIOR	PRESENT
a. Standing	Constant	Constant	i. Balancing	Constant	Constant
b. Walking	Constant	Constant	j. Bending	Constant	Constant
c. Sitting	Constant	Constant	k. Twisting	Constant	Constant
d. Lifting	Constant	Constant	l. Crouching	Constant	Constant
e. Carrying	Constant	Constant	m. Kneeling	Constant	Constant
f. Pushing	Constant	Constant	n. Crawling	Constant	Constant
g. Pulling	Constant	Constant	o. Reaching	Constant	Constant
h. Climbing	Constant	Constant	p. Handling/Dexterity	Constant	Constant

Under what conditions do you work? ☐ Outside Work ☐ Inside Work

Signature Date

History of Injury #1

History of Injury #2

Authorization to Release Medical Information and/or Disclosure of Medical Information

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my Providing or refusing to provide this authorization.

(The below box is for office use only)

REQUEST Medical Information FROM:	SEND Medical Information TO:
	ORANGE COUNTY MEDICAL
	Alexander Latteri, M.D., QME
Tel:	1211 W. La Palma Ave. Ste. 709
Fax:	Anaheim, CA. 92801
	Tel: (877) 336-3638 Fax: (714) 808-9393

I, _____ hereby authorize to release and/or disclose the medical information as indicated below to;

ORANGE COUNTY MEDICAL

Alexander Latteri, M.D., QME

Release and/or disclose records and information regarding:

Name _____

Date of Birth _____

Address _____

Telephone # _____

Duration: This authorization shall become effective immediately and shall remain in effect for 1 year from the date of signature.
Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance an this authorization before written revocation was received.
Redisclosure: I understand that the requester may not lawfully further use of disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Records to be release:

All reports of diagnosis, treatment, prognosis and recommendations, X-rays, MRI's, CT-Scans, or any other radiological exams or reports, as well as other data pertinent to the treatment rendered to me within your facility from

to present.

The information provided on these forms is true and provided by myself, the patient,_____ Dated_____
Initials

Date _____ ***Patient Signature***

Please save this document to your computer and e-mail to cnocmednet@sbcglobal.net, or print and bring it with you to your appointment.