

# RALPH N. STEIGER, M.D., INC.

Orthopaedic Surgery  
Phone 626.814.9191 • Fax 626.960.0943

## PATIENT INFORMATION SHEET

PATIENT'S NAME: \_\_\_\_\_

ADDRESS (NO P.O. BOX): \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ DRIVER LICENSE/I.D. #: \_\_\_\_\_

Please email for appointment reminder

AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

PLEASE CIRCLE: *RIGHT HANDED/LEFT HANDED* *MALE/ FEMALE*

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

EMPLOYER PHONE #: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

NOTIFY IN CASE OF EMERGENCY: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SPOUSE'S NAME (OR PARENT/LEGAL GUARDIAN IF PATIENT IS A MINOR):  
\_\_\_\_\_

EMPLOYER OF SPOUSE/PARENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SPOUSE/PARENT SSN: \_\_\_\_\_ SPOUSE/PARENT DOB: \_\_\_\_\_

I authorize payment of medical benefits to Ralph N. Steiger M.D. I agree to pay any balance of professional service charges which exceed insurance payment (excluding worker's compensation).

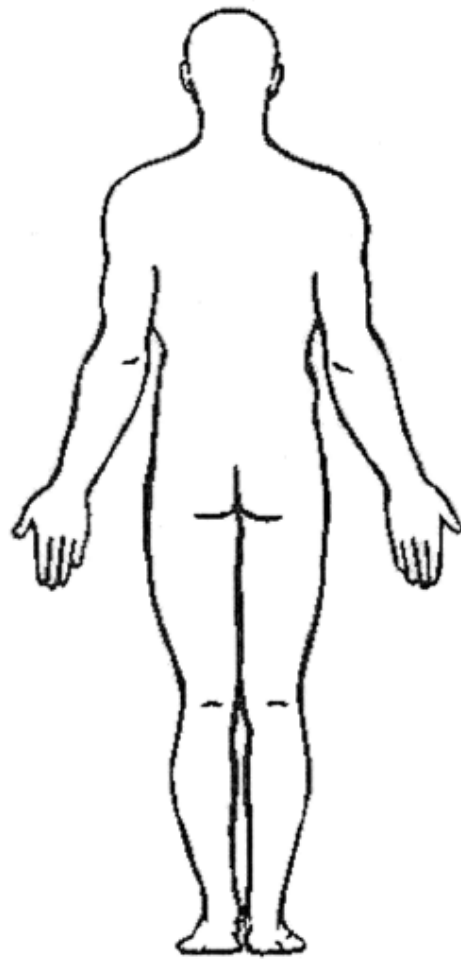
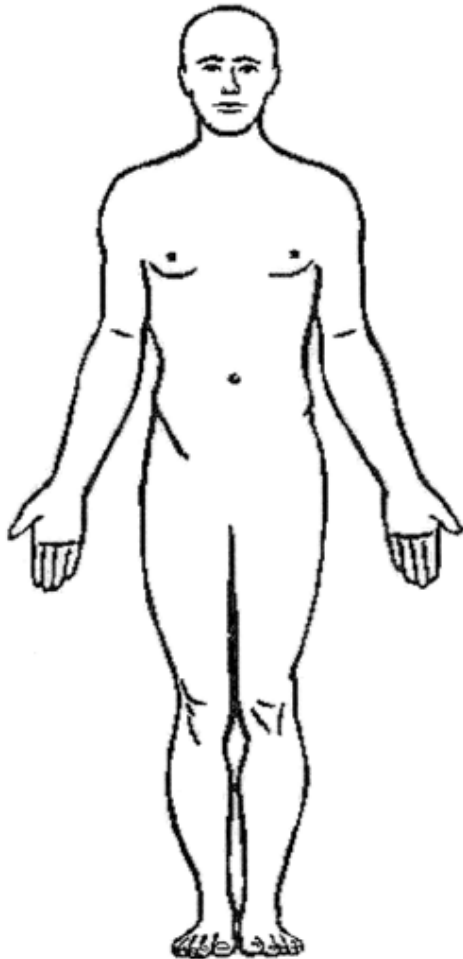
\_\_\_\_\_  
Patient's Signature (or authorized person)

\_\_\_\_\_  
Date

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DOI: \_\_\_\_\_

Please circle the body parts where you are having pain. Also mark if you are experiencing numbness (+++++), burning (/////), sharp/stabbing pain (~~~~~) or tingling (<<<<<).



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**MEDICAL RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_, born on \_\_\_\_\_, authorize  
\_\_\_\_\_ to release any and all medical records concerning me to  
Ralph N. Steiger, M.D.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Please fax to: (626) 960-0943

or mail to:

Ralph N. Steiger, M.D.  
P.O. Box 550  
West Covina, CA 91793-0550

# DESCRIPTION OF EMPLOYEES JOB DUTIES

(THIS FORM PERTAINS TO JOB AT TIME OF INJURY)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Employer at the time of the injury: \_\_\_\_\_

Occupation at the time of injury: \_\_\_\_\_

List when you began and when you stopped working for the above company:

From: \_\_\_\_\_ To: \_\_\_\_\_

Hours per day \_\_\_\_\_ Days per week \_\_\_\_\_ Overtime \_\_\_\_\_

## PHYSICAL REQUIREMENTS

**Circle one for each requirement:**

STAND:                      Constant    Frequent    Occasionally    Not at all

WALK:                      Constant    Frequent    Occasionally    Not at all

CLIMB:                     Constant    Frequent    Occasionally    Not at all

SQUAT:                    Constant    Frequent    Occasionally    Not at all

KNEEL:                    Constant    Frequent    Occasionally    Not at all

SIT:                        Constant    Frequent    Occasionally    Not at all

TWIST:                    Constant    Frequent    Occasionally    Not at all

BEND:                     Constant    Frequent    Occasionally    Not at all

PUSH:                     Constant    Frequent    Occasionally    Not at all

PULL:                     Constant    Frequent    Occasionally    Not at all

GRASP:                    Constant    Frequent    Occasionally    Not at all

GRIP:                     Constant    Frequent    Occasionally    Not at all

REACH:                    Constant    Frequent    Occasionally    Not at all

OVERHEAD WORK:                      Constant    Frequent    Occasionally    Not at all

TYPE/DATA INPUT:                    Constant    Frequent    Occasionally    Not at all

WRITING:                    Constant    Frequent    Occasionally    Not at all

**Name: <last>, <first>**

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Heaviest item lifted at work: Circle one

10 lbs 10-25 lbs 25-40 lbs 40-60 lbs 60-80 lbs 80-100 lbs 100+ lbs

Does the job require use of your feet to operate foot controls or for repetitive movement? YES NO

Does the job require you to work with or in:

Driving cars, trucks, forklifts or other moving equipment? YES NO

Working near hazardous equipment and machinery? YES NO

Walking on uneven ground? YES NO

Exposure to dust, gas or fumes? YES NO

Exposure to noise? YES NO

Exposure to extremes in temperature or humidity? YES NO

Work at heights of \_\_\_\_\_ feet?

Please provide a brief description of your job responsibilities at the time of the injury:

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## FUNCTION TEST

NAME: \_\_\_\_\_

Date: \_\_\_\_\_

### PLEASE CIRCLE THE NUMBER THAT CORRECTLY DESCRIBES YOUR PAIN

Rate how your pain is aggravated by Activity:

0 1 2 3 4 5 6 7 8 9 10

Rate how severe your pain is at its worst:

0 1 2 3 4 5 6 7 8 9 10

Rate how your pain is on the average:

0 1 2 3 4 5 6 7 8 9 10

Rate how severe your pain is right now, at this moment.

0 1 2 3 4 5 6 7 8 9 10

Rate how frequent you experience pain.

0 1 2 3 4 5 6 7 8 9 10

### PLEASE CIRCLE THE NUMBER THAT CORRECTLY DESCRIBES THE LIMITATION OR INTERFERENCE THAT YOUR PAIN CAUSES.

How much does your pain interfere with your ability to walk 1 block?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain prevent you from lifting 10 pounds?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to sit for ½ hour?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to stand for ½ hour?

0 1 2 3 4 5 6 7 8 9 10

**NAME:** <last>, <first>

How much does your pain interfere with your ability to get enough sleep?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to participate in social activities?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to travel up to 1 hour in a car?

0 1 2 3 4 5 6 7 8 9 10

In general how much does your pain interfere with your daily activities?

0 1 2 3 4 5 6 7 8 9 10

How much do you limit activities to prevent you pain from getting worse?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with you relationship with your family/partner/significant others?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to do jobs around your home?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to shower or bath without help from someone else?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to write or type?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to dress yourself?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to engage in sexual activities?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to concentrate?

0 1 2 3 4 5 6 7 8 9 10

NAME: <last>, <first>

**PLEASE CIRCLE THE NUMBER THAT CORRECTLY DESCRIBES THE EFFECT YOUR PAIN HAS ON YOU.**

Rate your overall mood this past week:

0 1 2 3 4 5 6 7 8 9 10

During this past week, how anxious or worried have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10

During this past week, how depressed have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10

During this past week, how irritable have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10

In general, how anxious are you about performing activities because they might make your pain/symptoms worse?

0 1 2 3 4 5 6 7 8 9 10



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**MEDICAL RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_, authorize Ralph N. Steiger, M.D., to release any and all medical records concerning me to \_\_\_\_\_ (Attorney of Record).

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

# WORK HISTORY

NAME: \_\_\_\_\_

Date: \_\_\_\_\_

**Please complete, giving details of your previous occupations prior to the injury you are being examined for today.**

**Occupation:** \_\_\_\_\_

List when you began and when you stopped working the above occupation:

From: \_\_\_\_\_ To: \_\_\_\_\_

BASIC PHYSICAL REQUIREMENTS:

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**Occupation:** \_\_\_\_\_

List when you began and when you stopped working the above occupation:

From: \_\_\_\_\_ To: \_\_\_\_\_

BASIC PHYSICAL REQUIREMENTS:

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**Occupation:** \_\_\_\_\_

List when you began and when you stopped working the above occupation:

From: \_\_\_\_\_ To: \_\_\_\_\_

BASIC PHYSICAL REQUIREMENTS:

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# ACTIVITIES OF DAILY LIVING

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## How much does your injury interfere with the following activities?

Please mark the Difficulty range column for each item.

Without Difficulty	With Some Difficulty	With Much Difficulty	Unable To Do
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### Self-care and Personal Hygiene:

Getting on/off toilet	_____	_____	_____	_____
Wiping yourself after using toilet				
Urinating				
Defecating				
Brushing Teeth				
Combing/brushing hair				
Washing/drying yourself				
Dressing yourself				
Tying shoes				

### Physical Activities:

Sitting				
Reclining				
Rising up from chair				
Standing				
Walking				
Climbing Stairs				
Working outdoors on flat ground				
Light housework including laundry				
Lifting				

### Hand Activities:

Grasping/Gripping				
Open milk carton				
Open previously opened jars				
Turn faucets on and off				
Open a car door				
Lifting				
Lift full cup/bottle/glass to mouth				
Make a meal				
Eating				
Cut food				

Name: <first> <last>

Date: \_\_\_\_\_

**How much does your injury interfere with the following activities?**

**Please mark one column for each item.**

**Without**

**With Some**

**With Much**

**Unable**

*Travel:*

Riding in a motor vehicle

Driving a motor vehicle

Getting in/out of car

Flying

*Sexual Function:*

Engage in sexual function

*Sleep:*

Restful Sleep

Fatigue during the day

*Communication:*

Writing

Typing

*Sensory Function:*

Feel what you touch

Tasting

Smelling

Hearing

Seeing

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**AUTOMOBILE INSURANCE INFORMATION  
ASSIGNMENT OF BENEFITS**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

INSURANCE CO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

INSURED: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_

**MED-PAY INFORMATION:**

AMOUNT OF MED-PAY: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

(IF DIFFERENT THAN ABOVE ADDRESS)

I hereby authorize the release of information necessary to process with any insurance claim and **ASSIGN BENEFITS PAYABLE TO RALPH N. STEIGER, M.D.** I understand that I am financially responsible for any balance not covered by my insurance. A copy of this signature is as valid as the original.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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**PRIVATE HEALTH INSURANCE INFORMATION AND AUTHORIZATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

DOB: \_\_\_\_\_

**PRIMARY INSURANCE CO.:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

SUBSCRIBER: \_\_\_\_\_

SUBSCRIBER DOB: \_\_\_\_\_ SUBSCRIBER SSN: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ ID NO: \_\_\_\_\_

PATIENTS RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

**SECONDARY INSURANCE CO.:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

SUBSCRIBER: \_\_\_\_\_

SUBSCRIBER DOB: \_\_\_\_\_ SUBSCRIBER SSN: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ ID NO: \_\_\_\_\_

PATIENTS RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

I hereby authorize the release of information necessary to process any insurance claim and ASSIGN BENEFITS OTHERWISE PAYABLE TO RALPH N. STEIGER, M.D. I understand that I am financially responsible for any balance not covered by my insurance. A copy of this signature is as valid as the original.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE