# 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**

RALPH N. STEIGER, M.D., INC
Orthopaedic Surgery
1250 S. Sunset Avenue, Suite 350
West Covina, CA  91790
Phone 626.814.9191  Fax 626.960.0943

# 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 |

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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## 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