**STEVEN S. ISONO, M.D.**

**Orthopaedic Surgery and Sports Medicine**

**311 Oak Street, Suite 113**

**Oakland, CA 94607**

**Phone (510) 844-4545 Fax (510) 208-3291**

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| **Patient Registration Form** | | | | | | | | | | | |
| Patient Name: | | | | | Social Security No: | | | | | | |
| Birth date: | Age: | Gender: Male Female | | | | | Right or Left Hand Dominant: | | | | |
| Home Phone: | | Cell Phone: | | | | | Work Phone: | | | | |
| Email Address | | | | | | |  | | | | |
| Address: | | | | | | City: | | | | Zip Code: | |
| Employer Name: | | | | | | Occupation/Title: | | | | Employment Duration: | |
| Employer Address: | | | | | | City: | | | | Zip Code: | |
| **Guarantor Information (skip if same as patient)** | | | | | | | | | | | |
| Guarantor name: | | | | | | Social Security No: | | | | | |
| Birth date: | | | | | | Relationship to Patient: | | | | | |
| Address: | | | | | | City: | | | | | Zip Code: |
| Home Phone: | | Cell Phone: | | | | | Work Phone: | | | | |
| **Emergency Contact Information:** | | | | | | | | | | | |
| Relationship: | | Primary Phone: | | | | | Secondary Phone: | | | | |
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| **Worker’s Compensation Information** | | | Claim# | | | | | | Date of Injury: | | |
| Insurance Name | | | Claim Address: | | | | | | | | |
| Claim Adjuster Name: | | | Phone# | | | | | | Fax# | | |
| Attorney Name | | | Attorney Phone# | | | | | | | | |
| **Medical History Form** | | | | | | | | | | | |
| Reason for Consultation: | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Date of onset/Injury: | | | | | | | | | | | |
| How did injury occur? | | | | | | | | | | | |
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| **Previous Surgeries and Dates:** | | | | | | | | | | | |
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| **Medical Conditions:** | | | | | | | | | | | |
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| **Current Medications:** | | | | | | | | | | | |
| Name of Medication | | | | Dosage (i.e., 100mg) | | | | Frequency (i.e., once daily) | | | |
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| **Drug Allergies:** | | | | | | | | | | | |
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| **Tobacco: No Yes How often?** | | | | | | | | | | | |
| **Alcohol: No Yes How often?** | | | | | | | | | | | |
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|  | | | | | | | | | | | |
| **Print Name** | | | | | | | | | | | |
| **Patient Signature Date** | | | | | | | | | | | |