The Ryu Hurvitz Orthopedic Clinic

2936 De La Vina Street First Floor
Santa Barbara CA 93105
Telephone (805) 963-2729
Fax (805) 963-3818

Worker's Compensation Patient Information

Last Name: _____ First: _____ Middle: _____

Nickname/Preferred Name: _____ Pronouns: _____ Sex: M / F

Date of Birth: _____ Age: _____ SS#: _____ Marital Status: _____

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Preferred: H / C

Email Address: _____

Job Title: _____ Brief Job Description: _____

Emergency Contact: _____ Phone Number: _____

Primary Care Practitioner: _____

Referring Practitioner (if applicable): _____

For Appointment Reminders: email / text

Please note that our physicians use different systems. Reminders are not sent for Dr. Richard Ryu.

Injury

Body Part Injured: _____ ☐ Right ☐ Left Date of Injury: _____

Brief description of the injury: _____

_____

Employer: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Adjustor: _____ Phone Number: _____

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Privacy Notice Acknowledgement

The Ryu Hurvitz Orthopedic Clinic is in strict adherence with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will not disclose your health information to any unauthorized sources.

I acknowledge the Notice of Privacy Practices from the Ryu Hurvitz Orthopedic Clinic. I am aware that a paper copy of this Notice will be provided at my request.

Initials: _____

Authorization of Disclosure

I hereby authorize discussion of my general medical condition, diagnosis, treatment, appointments, payment, and healthcare options with (check all that apply)**:**

☐ Spouse (name and phone number): _____

☐ Parent (name and phone number): _____

☐ Children (name and phone number): _____

☐ Other (relationship, name, and phone number): _____

Initials: _____

_____	_____	_____
Patient Name	Patient Signature	Date

If this form has been filled out on behalf of the patient:

_____	_____	_____
Name of Person Completing Form	Relationship to Patient	Date