

PATIENT #: _____

Email Address : _____

DATE: _____

PATIENT REGISTRATION

NAME: _____ SEX:(circle) M / F DOB: _____ AGE: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIV WID OTHER SS#: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

REFERRING PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIP CODE

AREA TO BE EXAMINED: _____ INJURY? (CIRCLE) YES / NO

EMPLOYER AT TIME OF INJURY: _____

DATE OF INJURY/ACCIDENT: _____ WORK RELATED? (CIRCLE) YES / NO

HOW INJURED? _____

HAVE X-RAYS BEEN TAKEN? (circle) YES / NO IF YES, WHERE, FACILITY? _____ DATE: _____

DOMINANT HAND (circle) RIGHT / LEFT EMERGENCY CONTACT AND PH#: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP PARTY NAME: _____ SSN: _____ DOB: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Name of Insured _____

Name of Insured _____

Social Security # _____ DOB: _____

Social Security # _____ DOB: _____

Employer _____

Employer _____

Insurance Co _____ PH#: _____

Insurance Co _____ PH#: _____

Address _____

Address _____

ID# _____ Group# _____

ID# _____

Referral _____

Referral _____

INDUSTRIAL INJURIES ONLY (COMPLETE IF APPLICABLE)

DATE OF INJURY: _____ CLAIM NUMBER: _____

NAME OF INDUSTRIAL CARRIER/ATTORNEY: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE: _____ FAX: _____

CLAIMS ADJUSTER / ATTORNEY: _____

PATIENT #: _____

DATE: _____

MEDICAL HISTORY

NAME: _____
LAST FIRST MI

ARE YOU BEING TREATED FOR ANY MEDICAL DISEASES? (FOR EXAMPLE: DIABETES, OSTEOPOROSIS, HEART, LUNGS, ULCERS, PULMONARY EMBOLI, HIGH BLOOD PRESSURE)

SURGICAL HISTORY: PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE LAST 10 YEARS WITH APPROXIMATE DATES

CURRENT MEDICATIONS: (LIST HERE OR ATTACH LIST)

ALLERGIES TO MEDICATIONS:

HAVE YOU EVER HAD ANY ORTHOPAEDIC INJURIES OR CONDITIONS INCLUDING FRACTURES OR DISLOCATIONS? IF NO CHECK HERE _____

SMOKER? (circle) YES / NO PACKS PER DAY: _____

HISTORY OF BLEEDING DISORDERS? (circle) YES / NO IF YES, DESCRIBE: _____

IF THERE ARE ANY RARE OR UNUSUAL DISEASES IN YOUR FAMILY, PLEASE LIST: _____

SPORTS/ACTIVITES: _____

HOW DID YOU HEAR ABOUT US?

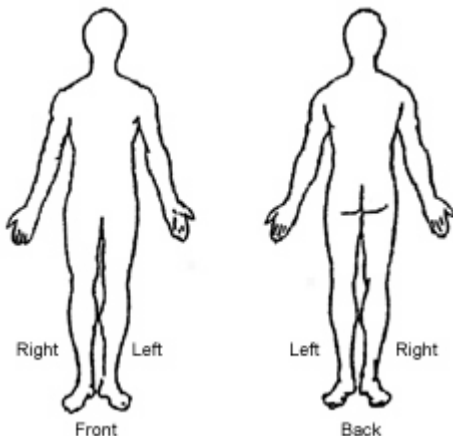
(circle) PHYSICIAN FAMILY/FRIEND WEBSITE PHYSICAL THERAPIST

CURRENTLY WORKING? (circle) YES / NO
(circle) FULL TIME PART TIME LIGHT DUTY USUAL JOB

MARK ON THE BODY OUTLINE AREAS WHERE YOU FEEL PAIN

CIRCLE THE NUMBER THAT DESCRIBES THE SEVERITY OF YOUR PAIN

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN



REVIEW OF SYMPTOMS: PLEASE CHECK ANY THAT APPLY TO YOU AT THE TIME:

CONSTITUTIONAL

- ___ FEVERS/CHILLS/SWEATS
- ___ UNEXPLAINED WEIGHT GAIN/LOSS
- ___ EXCESSIVE THIRST OR URINATION

CARDIOVASCULAR

- ___ CHEST PAIN
- ___ PALPITATIONS

RESPIRATORY

- ___ COUGH/WHEEZE
- ___ DIFFICULTY BREATHING

GASTROINTESTINAL

- ___ BLOOD IN BOWELS
- ___ ABDOMINAL PAIN
- ___ NAUSEA/VOMITING
- ___ DIARRHEA

NEUROLOGIC

- ___ HEADACHES
- ___ DIZZINESS/LIGHT HEADEDNESS
- ___ NUMBNESS
- ___ LOSS OF COORDINATION

PSYCHIATRIC

- ___ ANXIETY/STRESS
- ___ TROUBLE SLEEPING
- ___ DEPRESSION

OTHER

- ___ EASY BRUISING
- ___ RASH

PATIENT #: _____

DATE: _____

MEDICAL AUTHORIZATIONS

I AUTHORIZE YOU TO GIVE ME REASONABLE AND PROPER MEDICAL CARE BY TODAY'S STANDARDS. While we very much value our patients, failure to keep scheduled appointment may be subject to a \$35.00 charge. Similarly, our cancellation policy requires a telephone call at least one business day prior to a scheduled visit.

Date: _____ Signature: _____

INSURANCE POLICY:

As a courtesy, we will bill your insurance company for you if you have provided us with the insurance name, policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles, co-pays, and charges not covered by your insurance. Failure to submit payment for your portion of your bill may result in referring your account to a collection agency.

Date: _____ Signature: _____

TO OUR PATIENTS WITH MEDICARE:

Medicare law requires us to have you sign this form and keep it in your file. If you have any questions, feel free to ask our office staff. I request that payment of authorized Medicare benefits be made to the Orthopaedic Group of San Francisco for any services furnished me by the group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Date: _____ Signature: _____

TO OUR PATIENTS WITH INSURANCE OTHER THAN MEDICARE:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to the party who accepts assignment (The Orthopaedic Group of San Francisco.)

Date: _____ Signature: _____

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest. We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have to right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

Date: _____ Signature: _____