ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Patient Registration

Patient Information

First Name	Middle Initial	Last Name

Date of Birth	Social Security Number	Gender
		Male Female

Street Address	City	State	Zip Code

Marital Status (circle one)	Primary Care Physician
Married Single Divorced Widowed	

Phone number: Home	Cell	Work

verified by:

Email address	Driver's License #	Employer

Emergency Contact Name	Relationship	Phone

Date of injury/onset of symptoms	Was this an injury?	If yes, Where did your injury occur?
	NO YES	**WORK AUTO HOME SCHOOL OTHER:**

Insurance Information

Name of Primary Insurance:	Name of Secondary Insurance:
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:
Insured's Social Security number	Insured's Social Security number
ID #	ID #
Group #	Group #
Claims Address:	Claims Address:
Phone:	Phone:

Guarantor Responsible Party ☐ **Patient** ☐ **Other (if other please fill in information below)**

verified by:

Name:	Date of Birth	Relationship to patient:

Street Address	City	State	Zip Code

Phone number	Social Security Number	Employer

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a <u>cash patient</u> with payment in full due at the time of service.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Orthopaedic Specialty Institute
Medical Group of Orange County

SPORTS MEDICINE HEALTH QUESTIONNAIRE

Please answer each question as completely as possible.
This information will help diagnose and treat your condition

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____ Sex: ☐ Male ☐ Female *Height:* _____

Occupation: _____ *Weight:* _____

Who referred you to see me today? _____ *Dominant Hand:* ☐ right ☐ left

Body part to be examined: ☐ Right ☐ Left
☐ Shoulder ☐ Knee ☐ Elbow ☐ Hip ☐ Other _____

How and when did the injury occur or the symptoms begin?

At the onset of this problem did you notice any of the following?
☐ A "pop" ☐ Tearing sensation ☐ Immediate swelling

Has anyone previously treated you for this condition? _____

If so, when? _____

Previous Treatment: Check all that apply and indicate your response to treatment.

☐ NONE
☐ X-rays Results: _____
☐ MRI Results: _____
☐ CT scan Results: _____
☐ EMG _____ ☐ Physical therapy _____
☐ Chiropractor _____ ☐ Acupuncture _____
☐ Cortisone Injection How many in the last 12 months? _____ Any relief? _____
☐ Viscosupplementation (Orthovisc, Euflexxa, Synvisc) Last injection? _____ Any relief? _____
☐ Medication: ☐ Anti inflammatories _____ ☐ Pain medications _____ ☐ Other _____
☐ Brace _____ ☐ Orthotics/Insoles _____
☐ Other: _____

Patient Name: _____

Current Symptoms: Please check all that apply.

Do you currently have any of the following complaints?

☐ Catching/popping/locking ☐ Grinding ☐ Swelling ☐ Weakness
☐ Instability ☐ Numbness / tingling ☐ Loss of motion

Which of the following describes your pain?

☐ Sharp/Stabbing ☐ Aching ☐ Burning ☐ Throbbing
☐ Constant ☐ Intermittent ☐ Awakens me from sleep _____ nights per week
☐ During activities ☐ After activities

Where is your pain located?

☐ Front ☐ Back ☐ Inside ☐ Outside ☐ Top

What activities aggravate your condition?

What makes your condition feel better?

Have you had any prior injuries to this area of your body? *(If yes, please describe the injury and its prior treatment)*

Surgical History: Check any surgeries that you have had. *Please indicate the year of surgery to the best of your knowledge.*

☐ NONE ☐ Appendectomy ☐ Gall Bladder ☐ Vascular Bypass.... Where? _____
☐ Heart Surgery ☐ Hysterectomy ☐ Tonsillectomy
☐ Arthroscopic Surgery: ☐ Shoulder ☐ Knee ☐ Hip ☐ Other _____
☐ Total Joint Replacement: ☐ Knee ☐ Hip ☐ Shoulder
☐ Back Surgery: specify: _____
☐ Fracture Repair: specify: _____
☐ Other: _____
If you have had any problems with anesthesia, explain: _____

Patient Name: _____

Past Medical History: Have you ever had any of the following? Check all that apply and specify as indicated.

General:
☐ Cancer _____

Head-Ears-Eyes-Nose-Throat:
☐ Sleep apnea

Cardiac:
☐ High blood pressure
☐ Coronary artery disease
☐ Coronary stent/angioplasty
☐ Heart attack
☐ Mitral valve prolapse

Pulmonary:
☐ Asthma
☐ Emphysema
☐ COPD
☐ Pneumonia
☐ Tuberculosis

Endocrine:
☐ Diabetes
☐ Hypothyroid
☐ Hyperthyroid

Genitourinary:
☐ Bladder infections
☐ Venereal disease
☐ Kidney disease

Gastrointestinal:
☐ Ulcer disease
☐ GERD
☐ Gallstones
☐ Diverticulitis

Skin:
☐ Eczema
☐ MRSA/Staph infection
Date Treated: _____

Musculoskeletal:
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Osteoporosis
☐ Fibromyalgia
☐ Ankylosing spondylitis
☐ Scoliosis

Neurological:
☐ Seizures
☐ Balance problems
☐ Headaches
☐ Migraines
☐ Peripheral neuropathy
☐ History of stroke
☐ Multiple sclerosis

Hematologic:
☐ Bleeding disorder
☐ History of DVT/PE
☐ Blood clots

Infectious Disease:
☐ HIV
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

Psychiatric:
☐ Depression
☐ Bipolar
☐ Anxiety
☐ Manic
☐ History of drug dependency
☐ History of alcohol dependency

☐ NONE
☐ Other _____

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications.

☐ NONE

Name	Strength	Frequency	Name	Strength	Frequency

Allergies or Drug Reactions: Check all that apply.

☐ NO KNOWN DRUG ALLERGIES ☐ Codeine ☐ Morphine ☐ Demerol
☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ NSAID's
☐ Adhesive Tape ☐ Latex ☐ Iodine ☐ Other: _____

Social History: Please mark every area.

Tobacco use: ☐ Yes ☐ No ☐ Former ☐ Cigarettes ☐ Cigar ☐ Chewing ☐ Pipe ☐ Smokeless
Cigarettes: Pack(s) per day: _____ How many years: _____ If you quit, when? _____
Other tobacco use: Amount per day: _____ How many years: _____ If you quit, when? _____
Alcohol use: ☐ Yes ☐ No If yes, how many drinks per week? _____
Are you currently able to work? ☐ Yes ☐ No If not, when was your last day of work? _____
Sports and Recreational Activities: _____

Patient Name: _____

Review of Systems: Check any illnesses you currently have.

General:
- ☐ Fevers
- ☐ Weight loss or gain
- ☐ Difficulty sleeping
- ☐ Night sweats

Pulmonary:
- ☐ Shortness of breath
- ☐ Cough

☐ NONE

Genitourinary:
- ☐ Urinary frequency
- ☐ Urinary retention
- ☐ Urinary incontinence

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting

Cardiac:
- ☐ Chest pain

Neurological:
- ☐ Numbness or weakness
- ☐ Difficulty walking

Head-Ears-Eyes-Nose-Throat:
- ☐ Difficulty swallowing
- ☐ Difficulty breathing
- ☐ Vision loss or change
- ☐ Hearing loss or change
- ☐ Tinnitus (ringing in ears)

Family History: Has anyone in your family had any of the following problems?

☐ No significant past family history ☐ Unknown family history

Disease	Mother	Father	Brothers	Sisters	Daughters	Sons
High blood pressure/hypertension						
Heart attack/Heart surgery						
Diabetes						
Stroke						
Cancer (type)						
Arthritis						
Other (please specify)						

Primary Care Physician: _____

Telephone #: _____ City: _____

Would you like a letter sent to your doctor? ☐ yes ☐ no

Cardiologist: _____

Telephone #: _____ City: _____

***Please provide your pharmacy information. This will allow us to send medications to your pharmacy. ***

Pharmacy: _____

Address: _____

City: _____

Telephone #: _____

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____Date of Birth: ___/___/_____ MR #: _____

If minor, Parent/Guardian Name: _____

Release of Information

I authorize the release of information including diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _____

[ ] Child(ren)/Name(s): _____

[ ] Other: _____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # _____ [ ] my cell phone # _____.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) _____ between (time) _____.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: _____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____

Witness: _____ Date: _____

Orthopaedic Specialty Institute
Medical Group of Orange County

Acknowledgement of Receipt of Notice of Privacy Practices and Notices to Consumers

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices as well as Consumers Notices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices and/or Consumer updates at each appointment.

NOTICE TO CONSUMERS	NOTICE TO CONSUMERS
PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANT COMMITTEE (916) 561-8780 WWW.PAC.CA.GOV	MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA (800) 633-2322 WWW.MBC.CA.GOV

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

280 S. Main Street • Suite 200 • Orange, CA 92868 • Tel. (714) 634-4567 • Fax (714) 634-4569

ORTHOPAEDIC
SPECIALTY INSTITUTE

280 S. Main Street · Suite 200 · Orange, CA 92868 · Tel. (714) 634-4567 · Fax (714) 634-4569
16300 Sand Canyon Ave · Suite 511 · Irvine, CA 92618 · Tel. (949) 255-9890 · Fax (949) 255-9776

CONSENT FOR TREATMENT – NOTICE OF POLICIES

I hereby consent and authorize Orthopaedic Specialty Institute Medical Group of Orange County (OSI) healthcare providers to perform medical care, diagnostic tests, surgical care and other therapeutic measures, as may be indicated for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), healthcare provider(s), medical staff, and the company, of all responsibility resulting from my action.

I also authorize OSI, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payers (including but not exclusive of, private insurance, Medi-Cal, Medicare, Tricare, Work-Comp, etc.)

I acknowledge that I have been given the ability to review OSI's policies including Financial Policy.

FINANCIAL POLICY

- We will submit claims to your insurance company for all medical services rendered at OSI. Any other services related to your medical care not rendered at OSI (i.e. laboratory, pathology, hospital fees, outpatient surgery center fees, anesthesiologist, co-surgeon, etc.), will be billed by the entity providing those services. It is **your** responsibility to verify that OSI is part of your insurance plan. We will attempt to verify your eligibility and benefits with your insurance carrier; however, this does not guarantee that they will pay for the services provided, and you will remain financially responsible if they do not provide payment.

- **OSI accepts the following insurance plans:**

  - **Medicare** – pays 80% after the deductible has been met. We will bill your coinsurance for the remaining 20% as a courtesy; however, you are responsible for the 20% coinsurance of the Medicare allowable amount.
  - **Contracted PPOs and HMOs** – you are responsible for the payment of co-pay and deductible at the time of the service, as well as for any charges for which you failed to secure prior authorization (if necessary).
  - **Non-Contracted PPOs** – you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
  - **Self-Pay** (uninsured) - you are expected to pay in full at the time of the service.
  - **Worker's Compensation** – you are not responsible for any charges unless the case has been dismissed or denied.

Initials _____

- **Personal Injury/Motor Vehicle Accidents** - you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
- **Surgery Deposits** – once the decision for surgery is made, our surgery coordinator will contact your insurance carrier to confirm eligibility benefits and obtain authorization. The surgery coordinator will provide you with an estimated cost of your surgery. This amount will be collected as a deposit at or before the time of your pre-operative appointment.
- **Medical Records** – all medical records requests are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).
- **Divorce Related** – the parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all, or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- **Bad Debt** - patients who do not pay bills within 90 (ninety) days of the statement date, will be referred to a collections agency, and ***may be discharged from the practice for non-payment.***
- **Failed Appointment Charge for MRI** – we reserve the right to charge $25 (twenty-five) for each failed appointment not canceled at least 24 hours before the scheduled appointment time. This charge is not covered by your insurance.
- **Usual and Customary Rates** - our practice is committed to the best treatment for our patients. Our charges are considered usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary charges.

- **Financial Responsibility** – based on our contractual agreements with the insurance companies and our internal policies, we are informing you of the following:
  - Your health insurance deductibles and any expenses deemed not covered by your insurance company will be your financial responsibility.
  - All monies owed by you, such as office visits co-payments and non-covered services or supplies, are due at the time of the service.
  - If you are not prepared to pay any amounts due at the time of the visit, you will be asked to re-schedule the appointment, unless the physician determines that your medical condition prohibits this.

- **Method of Payment** - our office accepts the following forms of payment: credit cards, cash, money order, and checks. A $25 (twenty-five dollar) service charge will be assessed to your account for any returned check by your bank. This charge is not covered by your insurance.

Thank you for understanding our policies. If you have any questions or concerns, please do not hesitate to contact our office at **(714) 634-4567.**

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose to revoke them in writing.

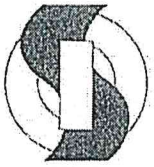
_____

(Signature of Patient or Authorized Representative) (Printed Name) (Date)

_____

(If signed Above by Representative, Relationship of Signer to Patient) (Name of Patient if Different from Above)

Initials _____



Orthopaedic Specialty Institute
Medical Group of Orange County

Patient Registration

Patient Information

First Name	Middle Initial	Last Name

Date of Birth	Social Security Number	Gender
		Male Female

Street Address	City	State	Zip Code

Marital Status (circle one)	Primary Care Physician
Married Single Divorced Widowed	

Phone number : Home	Cell	Work

verified by:

Email address	Driver's License #	Employer

Emergency Contact Name	Relationship	Phone

Date of injury/onset of symptoms	Was this an injury?	If yes, Where did your injury occur?
	NO YES	WORK AUTO HOME SCHOOL OTHER:

Insurance Information

Primary Insurance Carrier	Secondary Insurance Carrier
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:
Insured's Social Security number	Insured's Social Security number
ID #	ID #
Group #	Group #
Claims Address:	Claims Address:
Phone:	Phone:

Guarantor Responsible Party ☐ **Patient** ☐ **Other (If other please fill in information below)**

verified by:

Name:	Date of Birth	Relationship to patient:

Street Address	City	State	Zip Code

Phone number	Social Security Number	Employer

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

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This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Concussion and Health History

Name : _____ Age: _____

Date of Evaluation: _____ Referral Source:_____

History of Current Injury:

Date of Concussion: _____

Sport: _____ Position: _____

Injury description:

_____

_____

Returned to Play: Y / N Hospital/ER: Y / N CT / MRI: Y / N

Symptoms Immediately Following Concussion:

	Y/N
Headache	
Nausea	
Vomiting	
Balance Problems	
Dizziness (spinning or movement sensation)	
Lightheadedness	
Fatigue	
Trouble falling asleep	
Sleeping more than usual	
Sleeping less than usual	
Drowsiness	
Sensitivity to light	
Sensitivity to noise	
Irritability	
Sadness	
Nervous/ Anxious	
Feeling more emotional	
Numbness or tingling	
Feeling slowed down	
Feeling like "in a fog"	
Difficulty concentrating	
Difficulty remembering	
Visual problems	
Other	

Post-Concussion Exertional Activity: Have you done any of the below activities following your concussion?

Physical: Weights / Running / Practice / Games
Symptoms Worse with activity: Y / N

Cognitive: School Work / Job / Computer Work / Other:_____
Symptoms Worse with activity: Y / N

Medical History:

Current medications: _____

Past Medical History/Medical History:

_____

_____

History of concussion: Y / N
# of diagnosed concussions:_____ # w/in the last 1 year:_____

Description of previous concussions:_____
_____
_____
_____

Other History:

Migraines? Y / N
Other Headache Disorder? Y / N
Seizure DO/Epilepsy? Y / N
Depression/Anxiety? Y / N
ADD/ADHD? Y/N

If yes to any of the above: Medications?_____

Social/Educational History

Other Sports Played: _____

School Name (if applicable):_____

Occupation/Work (if applicable):_____

Learning Disability? Y / N (type: Math/Reading, etc.)_____

Tobacco Use: Y / N

ORTHOPAEDIC
SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____Date of Birth: ___/___/_____ MR #: _____

If minor, Parent/Guardian Name: _____

Release of Information

I authorize the release of information including diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _____

[ ] Child(ren)/Name(s): _____

[ ] Other: _____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # _____ [ ] my cell phone # _____.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) _____ between (time) _____.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: _____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Medical Group of Orange County

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PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE

(916) 561-8780

WWW.PAC.CA.GOV

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(800) 633-2322

WWW.MBC.CA.GOV

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ORTHOPAEDIC
SPECIALTY INSTITUTE

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16300 Sand Canyon Ave · Suite 511 · Irvine, CA 92618 · Tel. (949) 255-9890 · Fax (949) 255-9776

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I also authorize OSI, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payers (including but not exclusive of, private insurance, Medi-Cal, Medicare, Tricare, Work-Comp, etc.)

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(Signature of Patient or Authorized Representative)	(Printed Name)	(Date)
(If signed Above by Representative, Relationship of Signer to Patient)	(Name of Patient if Different from Above)	

Initials_____