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 _____

New Patient Information Form

Asif Jillani, M.D

Patient name: _____ DOB: _____ Date: _____

Current Problem:

What is the area to be examined: _____ R or L
Describe your pain / discomfort: _____
What makes it worse: _____
What makes it better: _____
Do you have pain, numbness or tingling / radiating down your arms or legs: _____
When did you first notice it: _____
How did it start: _____
Have you ever had anything like this before: _____
Do you ever notice any (circle): Locking Popping Catching Clicking Give – way
If this is a Work Comp, injury, was it reported / when: Y / N, __/__/____ Date of injury: __/__/____
Describe the details about the injury: _____
What are your current work restrictions? _____
How long have you worked at this job? _____
Have you had any other work related injuries, describe? _____

Prior treatment for this problem:

Epidural Injections, cortisone or steroid injections: _____
Surgery: _____
Medications: _____
Therapy: _____
Other: _____

Past Diagnostic Studies (when):

X-rays: _____
MRI: _____
CAT Scan: _____
EMG (nerve studies): _____

** This form and the information contained here is a part of your medical record. As such, it is confidential and will be kept in the office. The information contained here will not be released to any person / entity without your expressed written authorization.

Orthopedic Specialty Institute

Asif Jillani M.D.

Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate full with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicines will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use_____Pharmacy, located at _____, Telephone number_____, for filling prescriptions for all of my pain medicines.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this sate's Board or Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

New Patient Information Form

Asif Jillani, M.D

Medical Information:

Drug Allergies: _____

Which is your dominant hand (circle one): Right / Left or Neither

What medications are you currently taking (including dosage): _____

_____

Do you have any medical problems (diabetes, thyroid disease, high blood pressure, heart disease, rheumatologic disease): _____

Do any of your immediate family members (i.e Father, Mother, Siblings) have any medical problems (cancer, heart disease, high blood pressure, rheumatologic disease) : _____

_____

Name any operations you have had (when): _____

Pain Score (Circle one): 1 2 3 4 5 6 7 8 9 10

Habits:

Do you smoke? Yes / No How many packs per day? _____ How many years? _____

Do you drink any alcohol? Never / rarely / 1-2 per month / 1-2 per week / 1-2 per day / 3-5 per day / > 5 per day

General Systems:

Have you had any recent problems with:

____ Weight loss	____ Cough / wheeze	____ Headaches
____ Fevers/ Chills	____ Shortness of Breath	____ Dizziness
____ Night sweats	____ Chest pain	____ Loss of consciousness
____ Nausea / Vomiting	____ Palpitations	____ Blurry vision
____ Upset stomach	____ Change in bowel / bladder	____ Loss of vision
____ Diarrhea	____ Frequent urination	____ Skin rash

Female only:

Is there any chance that you are pregnant? Yes / No

When was your last menstrual cycle: _____

** This form and the information contained here is a part of your medical record. As such, it is confidential and will be kept in the office. The information contained here will not be released to any person /entity without your expressed written authorization.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this_____day of _____, _____.

Patient signature: _____

Physician signature: _____

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

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE

(916) 561-8780

WWW.PAC.CA.GOV

NOTICE TO CONSUMERS

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: _____

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