ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

Spine Patient Questionnaire

Name: _____ Primary Dr. Address: _____

DOB: _____ Age: _____ Hand Dominance: ☐ R ☐ L _____

Today's Date: _____ Phone Number: _____

☐ Male ☐ Female Pregnant? ☐ Yes ☐ No Referring Physician: _____

Height: _____ Weight: _____ _____

Referring Dr. Address: _____

Primary Physician: _____ Phone Number: _____

Chief Complaint: _____

Date of Injury: _____ Injured at: _____ County of: _____

Did your pain start: ☐gradually ☐suddenly

Are your symptoms now: ☐worse ☐better ☐no change

Degree of current pain: ☐none ☐mild ☐moderate ☐severe

How often do you experience the pain? ☐constant ☐intermittent

What is your pain scale (scale of 1-10; 10 being the worst pain)? _____

Describe your pain: ☐aching ☐burning ☐sharp ☐stabbing ☐numbness

☐tingling ☐ _____

What is your back pain to leg pain ration (i.e. 100% back/0%leg)?

☐N/A ☐100/0 ☐90/10 ☐80/20 ☐70/30 ☐60/40 ☐50/50 ☐40/60 ☐30/70 ☐20/80 ☐10/90 ☐0/100

What is your neck pain to arm pain ratio (i.e. 100% neck/0% arm)?

☐N/A ☐100/0 ☐90/10 ☐80/20 ☐70/30 ☐60/40 ☐50/50 ☐40/60 ☐30/70 ☐20/80 ☐10/90 ☐0/100

Where is your pain located? (check all that apply and circle side)

☐neck ☐neck and arm(s) R or L ☐arm(s) R or L

☐back ☐back and arm(s) R or L ☐leg(s) R or L

What aggravates your pain? (standing, sitting, etc.) _____

What relieves your pain? (lying down, sitting, etc.) _____

Do you have numbness? If so, where? _____

Do you have weakness? If so, where? _____

Do you have night pain? _____ Does it wake you up from sleep? _____

Do you have bowel or bladder problems? ☐incontinence ☐constipation ☐hesitancy

Are there any associated symptoms (i.e. nausea, loss of balance, etc.)? _____

_____

What treatments have made your pain better? _____

What treatments have made your pain worse? _____

Have you been in a physical therapy program? ☐yes ☐no Did it help you? ☐yes ☐no

When did you participate in physical therapy? ☐Less than 3 months ago ☐More than 3 months ago

Where did you go to physical therapy for this condition? _____

Are you currently working? ☐no ☐yes what type of work? _____

☐full duty ☐modified duty: _____

Are you able to perform your usual duties? ☐yes ☐no Date last worked? _____

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

Spine Patient Medical and Surgical History

Past Medical History

Check all items that apply and describe below if necessary. Otherwise check "none."				NONE
☐ Anesthesia problems:	Describe:			☐
☐ Heart problems:	☐Heart attack	☐Heart failure	☐Stroke	☐
☐ Circulation problems:	☐High blood pressure	☐Poor circulation		☐
☐ Lung problems:	☐Emphysema	☐Asthma ☐Lung Disease ☐Pneumonia ☐Tuberculosis		☐
☐ Diabetes:	☐Date diagnosed:	Controlled with: ☐Insulin ☐Oral meds		☐
☐ Neuropathy:	☐Loss of Feeling:	☐Hands	☐Feet	☐
☐ Endocrine problems:	☐Thyroid	☐Adrenal	☐Pituitary	☐
☐ Blood problems:	☐Anemia	☐Bleeding disorder		☐
☐ Blood clots:	☐Blood clot in leg	☐Blood clot in lung		☐
☐ Cancer:	Type(s):			☐
☐ Stomach problems:	☐Ulcers	☐Hiatal hernia	☐Gastric reflux	☐
☐ Kidney problems:	☐Kidney failure	☐Kidney stones		☐
☐ Liver problems:	☐Hepatitis	☐Cirrhosis		☐
☐ Mental illness:	☐Depression	☐Seizures	☐Alcoholism	☐
☐ Bone/Joint problems:	☐Fractures	☐Osteoarthritis	☐Osteoporosis	☐
	☐Gout	☐Rheumatoid arthritis		
☐ Immune problems:	☐AIDS	☐HIV	☐Other	☐
☐ Descriptions/Other:				

Past Surgical History ☐ no other surgery ☐ use back of page if more space needed

Type of Surgery	Date	Surgeon/Hospital

Medications (include vitamins and herbs) ☐no medications ☐use back of page if more space needed

Medication/Strength	Dosage	Reason	Medication/Strength	Dosage	Reason

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

Spine Patient Medical and Surgical History

Allergies ☐no allergies ☐use back of page if more space needed

Allergy	Reaction(s)	Allergy	Reaction(s)

Family History (check all that apply) ☐none apply

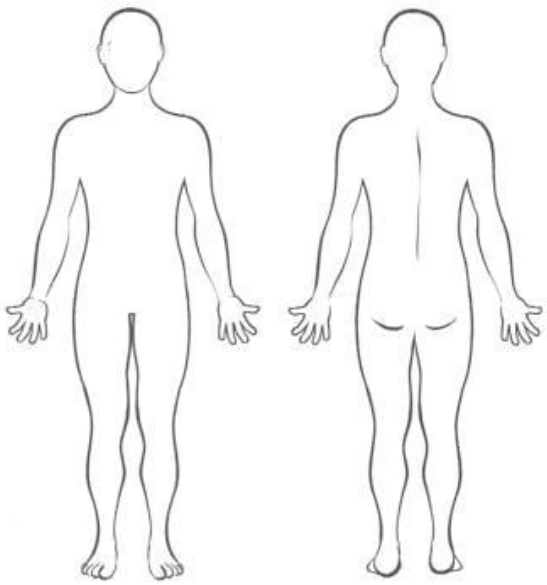
☐heart problems ☐lung problems ☐kidney problems ☐stroke ☐arthritis
☐bleeding problems ☐alcoholism ☐seizures ☐spine problems ☐cancer
☐mental illness ☐hypertension ☐diabetes ☐gout
☐other: _____

_____

Social History (check all that apply)

Occupation:				
Work Status:	☐Employed	☐Retired	☐Unemployed	☐Disability leave
Marital Status:	☐Single ☐Co-habiting	☐Married	☐Divorced	☐Widowed
Who do you live with:	☐Alone ☐Other	☐Spouse/Sig. Other	☐Children	☐Roommate
Tobacco Use:	☐Never ☐Packs per day ____	☐Cigarettes For _____ years (total)	☐Cigar	☐Pipe chew ☐Quit _____ years ago
Alcohol Use:	☐Never ☐Alcoholic	☐Rare ☐Recovering Alcoholic	☐Social	☐Frequent (more than 2x per week)
Drug Use:	☐Never Types of Drugs:	☐In past	☐Currently	☐In treatment

Please mark the areas on your body where you are having symptoms. Use the symbol "XXXX." Just to complete the picture, please draw your face.



ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

Spine Patient Medical and Surgical History

Review of Systems

Check all items that apply and describe below if necessary. Otherwise check "none."					NONE
☐Constitutional:	☐Weight loss	☐Weight gain	☐Fever	☐Chills	☐
☐Eyes:	☐Reading glasses	☐Change of vision			☐
☐Ears:	☐Hearing loss	☐Ear pain	☐Vertigo (dizziness)		☐
☐Nose/Mouth/Throat:	☐Nosebleeds	☐Hoarseness	☐Bleeding gums	☐Tooth/gum trouble	☐
☐Lungs:	☐Cough	☐Shortness of breath	☐Wheezing	☐Snoring	☐
☐Stomach:	☐Nausea	☐Ulcers	☐Vomiting	☐Stomach pain	☐
☐Bowels:	☐Diarrhea	☐Constipation	☐Bloody stool	☐Black stools	☐
☐Urinary Tract:	☐Difficulty starting urination		☐Frequent or burning urination		☐
☐Heart:	☐Chest pain	☐Palpitations	☐Abnormal heart beat	☐Swollen ankles	☐
☐Musculoskeletal:	☐Joint pain ☐Muscle pain	☐Swelling	☐Instability	☐Stiffness	☐
☐Skin:	☐Rashes ☐Poor healing	☐Itching	☐Skin changes	☐Redness	☐
☐Neuropathy:	☐Loss of feeling in:	☐Hands	☐Feet	☐Numbness	☐
☐Neurologic:	☐Seizures ☐Dizziness	☐Headaches	☐Memory loss	☐Uneasy gait	☐
☐Psychologic:	☐Sleep disturbance	☐Hallucinations	☐Frequent anxiety	☐Depression	☐
☐Blood:	☐Bleeding/bruising	☐Swollen lymph nodes	☐Blood clots	☐Anemia	☐
☐Non-Drug Allergies:	☐Foods	☐Seasonal	☐Other:		☐
☐Description/Other:					

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

SOUTH ORANGE COUNTY ORTHOPAEDICS, INC

Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____

_____

_____

Where did your accident/injury occur? _____

_____

_____

How did your accident/injury occur? _____

_____

_____

Will this accident/injury involve litigation currently or in the future? _____

_____

_____

☐ My visit is not related to a motor vehicle accident, work-related injury, school injury, or any other injury for which another party is responsible.

Signature: _____ Date: _____

Thank you for your assistance.

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Consent to Treat and Financial Policy

Authorizations

I hereby consent and authorize Orthopaedic Specialty Institute Medical Group of Orange County (OSI), including divisions of OSI, care providers to perform medical care, diagnostic tests, surgical care, and other therapeutic measures, as may be directed for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that by doing so I release my physician(s), health care provider(s), medical personnel, and the company, from all liability resulting from my action.

I also authorize OSI, all physician associates, and all partner agencies to collect, maintain, and disclose information that may be required for the processing of any third-party payer claims (including, but not limited to, insurance, Medi-Cal, Medicare, TRICARE, work-comp, etc.).

Additionally, Principal Care Management (PCM) services may be recommended to you as part of your treatment plan. The goal of PCM services is to optimize your care by providing a comprehensive, patient-centered approach to manage pre-surgical needs and ensure continuity of care throughout the perioperative period. As part of PCM, you will receive structured recording of health information, 24/7 access to care, comprehensive care management and planning, coordination of perioperative care, and physician supervision.

Notice of Privacy Practices (HIPAA) Acknowledgement

I acknowledge that I have received and/or have been offered a copy of Orthopaedic Specialty Institute's Notice of Privacy Practices, which describes how medical information about me may be used and disclosed and how I can access this information. I understand that this notice is also available upon request and may be updated from time to time.

Open Payments Database Disclosure

I understand that under the Physician Payments Sunshine Act (Open Payments), certain payments or other transfers of value made to physicians and teaching hospitals by pharmaceutical and medical device companies are reported and publicly disclosed by the Centers for Medicare & Medicaid Services (CMS). This information is publicly available at: https://openpaymentsdata.cms.gov. I understand that my provider may be listed in this database.

Consent for Electronic Communication

I authorize OSI to contact me via phone, text, voicemail, or email for appointment reminders, billing inquiries, and other healthcare-related communications. I understand that while OSI will take reasonable precautions to protect my privacy, these methods of communication may not be fully secure. I understand that I may unsubscribe from receiving text or email notifications at any time.

Telehealth Consent

I understand that OSI may offer healthcare services using telehealth technology, including telephone and video consultations. I consent to receive care in this manner and understand the risks and limitations, including potential issues with confidentiality and data security.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification and insurance card to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you, if required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with our office at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

All outstanding balances are the responsibility of the patient. If you have been billed more than once without payment, you may be unable to schedule an appointment or be required to reschedule an existing appointment. Chronic non-payment of your outstanding balances can constitute severance from the Practice.

Insured Patients

As a courtesy to you, we will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service. OSI is recognized as a specialist care provider. Due to our specialist classification, co-pays may be higher than your PCP. It is your responsibility to know what your co-pay would be with OSI, and it is our responsibility to collect that co-pay.

Surgery/Procedures – Medical billing for all major procedures generally involves a set fee for the procedure and follow up visits for a period of 10- or 90-days following treatment. This is commonly referred to as "Global Surgical Package" and does not include initial consultation or evaluation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed; diagnostic tests and procedures including x-rays; DME, Custom Splinting, treatment for post-op complications that require additional surgeries, additional cast applications and supplies required; or a more extensive procedure if the less extensive procedure fails, and services provided by the Anesthesiologist and the facility.

Patients with balances on their accounts will be required to make a payment before surgery/procedure can be scheduled. Upon scheduling surgery/procedure, OSI will create a patient estimate for you so that you are aware of what your financial responsibility will be. This estimate does not include financial responsibility for Anesthesia and facility care (which are not part of OSI); these estimates will be provided by these vendors. OSI will submit the bill to your insurance company. Upon payment and/or receipt of explanation of benefits, any balances owed by you will be your responsibility.

Non-Participating Insurance – Please be advised that OSI is not participating providers for the following insurance plans: Aetna Savings, Aetna Whole Health, Aetna Premier, Anthem Select, Anthem Covered California CA/Exchange, Anthem High Performance Network, Blue Shield High Performance Network, Blue Shield Medicare Select, Blue Shield PERSGold, Blue Shield Promise, Blue Shield Tandem, Beech Street, Cigna Indemnity, Health Net Ambetter, Health Net Enhanced, Health Net Community Care, Kaiser Permanente, Multiplan, PHCS, United Healthcare Core Access, United Healthcare Navigate, and certain Health Management Organizations (HMO). It is the patient's responsibility to verify network participation.

In cases where OSI is not recognized as a participating provider and considered "out-of-network" for your plan, OSI will bill your insurance carrier its full charge and you will be responsible for any unpaid balance.

Medicare Patients – If I am a Medicare beneficiary, I understand that I may be financially responsible for services not covered or denied by Medicare. I acknowledge that I may be asked to sign an Advance Beneficiary Notice (ABN) prior to receiving such services.

Accident Reports/Questionnaires – Prior to processing claims, your insurance carrier may request additional information in the form of an accident questionnaire. Please return the questionnaire or contact your insurance carrier with the information even if you did not sustain an accident. We will process the entire balance to patient responsibility.

If you are unable to pay your account in full, please contact the billing department for alternative payment arrangements. Accounts left unpaid after ninety days may be transferred to an outside collection agency.

Motor Vehicle Accidents (MVA) Insured and Third-Party Patients

If you are injured in and/or around a motor vehicle you must report the injury to your motor vehicle insurance company. All patients receiving care for motor vehicle accident-related injuries will be treated as fee-for-service. Patients may submit their invoices to their auto insurance or third-party insurance for reimbursement. We regret that we are not able to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request, provided we are furnished with a copy of the settlement agreement at the time of service.

Workers' Compensation

OSI providers accept workers' compensation on a case-by-case basis. If your visit is work-related, we will need the case number, carrier name, and authorization to treat you prior to your visit to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted, your appointment may be rescheduled until claim information and authorization is provided.

If your case is denied, we will bill your private health insurance carrier. If the claim is not paid within 30 days, the balance will become your responsibility and is due in full within thirty days of the billing date. If you are unable to pay your account in full, please contact our business office for payment arrangements. After ninety days, if payment arrangements have not been made, unpaid balances may be transferred to an outside collection agency.

Uninsured Patients

OSI will follow the Federal Government Law "No Surprises Act". The amount you will pay is determined from a defined fee schedule and considered payment in full. You understand that the time-of-service discount applies to all patients for services provided. You understand that OSI has agreed to furnish the healthcare services you have requested, or for which may be recommended by a healthcare provider of OSI in exchange for payment in full at the time of service. A time-of-service discount is offered when payment is made at the time of service; otherwise, the amount owed will be billed at the usual and customary rate. You further acknowledge and attest that you do not have insurance coverage for this service.

Office Visits – Patients without billable insurance (self-pay) are required to pay for their visits at the time of service. OSI will provide a Good Faith Estimate of anticipated services before your appointment. Please note that additional charges may apply based on the provider's evaluation. These may include services such as injections, x-rays, casting, or supplies received during your visit.

Surgery – OSI will provide you with a Good Faith Estimate of any services required at the time of the estimate. There may be new services added as the provider performs the surgery. Payment is required prior to surgery. A payment plan will be established with a credit card on file for patients who are unable to pay the full amount.

Exclusions – The discounts referred above do not apply in cases of motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

All remaining balances are due in full within thirty days of the billing date unless alternative payment arrangements have been made with the billing office. Accounts left unpaid after ninety days may be transferred to an outside collection agency.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third-party checks).

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative payment arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care will be required to pay for their bad debt obligation before scheduling future appointments. In addition, you may be required to pay your deductible and any co-insurance at the time of service. Patients who were granted bankruptcy may not be allowed to schedule future appointments.

Service Fees – The following are some, but not all, service fees assessed by the practice. Service fees are subject to change at the discretion of the practice.

Missed Appointments – All appointments that are missed or not cancelled within 24 hours are subject to a no-show fee. This applies to same-day cancellations. The fee for missed appointments is $30.00 and includes MRI and therapy visits. Appointment reminders are provided 5 days in advance via text and/or e-mail to help you meet the 24-hour window. Notifying us timely helps us- to help you- remain compliant with treatment and get you rescheduled ASAP to help ensure a great outcome. It also helps us to help other patients that need those appointments.

Disability, Insurance, or Employee Forms - OSI will complete insurance, disability, and employer forms provided by the patient. Because these forms are often detailed and time-consuming, they cannot be completed immediately. Patients are asked to leave the forms at the office with any applicable sections already filled out. OSI staff will complete the forms within ten (10) business days. A fee per form applies and must be paid in full at the time of the request or before the completed form is released.

Returned Check Fees – You understand that if OSI receives a returned check written by you or on your behalf, you will be charged a returned check fee of $25.00 and will be required to pay using your credit card. Failure to repay the returned check and the returned check fee may result in collection proceedings and may lead to dismissal of you as a patient from OSI.

Medical Records – Requests for copies of your medical records must be submitted in writing. Requests can be made in person at any OSI location, by fax, email, or via our medical records portal. In accordance with applicable state and federal law, OSI will provide copies of requested medical records within 15 business days from the date the request is received. If records are stored off-site, an additional 5 business days may apply. A preparation fee may apply, and costs for copies, shipping, and handling will be added as applicable. Patients may be required to complete a Medical Record Release Authorization Form before the request is processed.

Final Costs of Services – You understand that OSI representatives can only estimate potential costs and cannot guarantee final costs until all procedures have been performed and documentation has been processed by your insurance carrier. You further understand that final costs are determined by your insurance carrier, including coverage and authorization limitations, and that insurance payment is not a guarantee. Payment is subject to the terms, conditions, and coverage specifics of your individual plan. Estimates provided are based on the information available from your insurance carrier at the time the estimate is given. If your insurance processes claims differently or adjusts payments based on their policies or coding interpretations, this is not the responsibility of OSI. Final billing may differ from initial estimates based on actual processing by your insurance carrier.

Minors of Divorced Parents and Child Custody Cases

Both parents are financially responsible for care rendered to minor children. OSI reserves the right to bill the parent who attends and signs the financial policy until a court order is provided.

Collections Process

Any balances determined as patient responsibility that remain unpaid after 90 days will be subject to an in-house review. You understand that you may not be able to schedule any further appointments with OSI, receive medication refills, or seek medical advice of any kind from OSI until this collection balance is paid in full except if you are hospitalized or in a limited post-operative follow-up period. In the event your account is sent to an outside collection agency, you understand that you will be required to pay collection company fees. You will also be responsible for attorney fees and court costs should the collection proceedings advance to litigation.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Discharge of a Patient

You understand that OSI has the right to discharge any patient from this practice at any time for various reasons, including but not limited to, failure to abide by OSI financial policies, noncompliance of recommended treatment plans, drug-seeking activity, and any abuse of OSI healthcare providers and staff. If this occurs, you understand that your medical records will be released to a physician or healthcare facility of your choice only after an appropriately signed documentation is received by OSI. You further understand that once discharged from OSI, you will not be allowed to return as a patient of OSI in the future.

I have read and understand the financial policies, procedures and authorizations of Orthopaedic Specialty Institute to include payment methods, uninsured accounts, financial responsibility resulting from insurance, insurance policy provisions, collection activities, service fees, economic hardship, discharge of patient, out-of-network, final cost of services and authorizations to include assignment of benefits, record usage provision, consent for medical treatment, consent to use and disclosure of health information for treatment, payment and operations, appointed representative and notice of privacy practices. I understand that these policies, procedures and authorizations outlined in the Financial Policies and Procedures may be amended from time to time at the discretion of the practice and apply to me. I authorize the use of a copy of this authorization in place of the original. I authorize my insurance benefits to be paid directly to Orthopaedic Specialty Institute (OSI). I understand that I am financially responsible for any charges not covered by my insurance. I also authorize OSI to release any information required to process my claims.

Signing below indicates that you are acknowledging and agreeing to all of the above. You further understand and agree that your consents/assignments remain in effect until you decide 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

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.

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

SOUTH ORANGE COUNTY ORTHOPAEDICS, INC

Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____

_____

_____

Where did your accident/injury occur? _____

_____

_____

How did your accident/injury occur? _____

_____

_____

Will this accident/injury involve litigation currently or in the future? _____

_____

_____

☐ My visit is not related to a motor vehicle accident, work-related injury, school injury, or any other injury for which another party is responsible.

Signature: _____ Date: _____

Thank you for your assistance.

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

Spine Patient Medical and Surgical History

Review of Systems

Check all items that apply and describe below if necessary. Otherwise check "none."					NONE
☐Constitutional:	☐Weight loss	☐Weight gain	☐Fever	☐Chills	☐
☐Eyes:	☐Reading glasses	☐Change of vision			☐
☐Ears:	☐Hearing loss	☐Ear pain	☐Vertigo (dizziness)		☐
☐Nose/Mouth/Throat:	☐Nosebleeds	☐Hoarseness	☐Bleeding gums	☐Tooth/gum trouble	☐
☐Lungs:	☐Cough	☐Shortness of breath	☐Wheezing	☐Snoring	☐
☐Stomach:	☐Nausea	☐Ulcers	☐Vomiting	☐Stomach pain	☐
☐Bowels:	☐Diarrhea	☐Constipation	☐Bloody stool	☐Black stools	☐
☐Urinary Tract:	☐Difficulty starting urination		☐Frequent or burning urination		☐
☐Heart:	☐Chest pain	☐Palpitations	☐Abnormal heart beat	☐Swollen ankles	☐
☐Musculoskeletal:	☐Joint pain ☐Muscle pain	☐Swelling	☐Instability	☐Stiffness	☐
☐Skin:	☐Rashes ☐Poor healing	☐Itching	☐Skin changes	☐Redness	☐
☐Neuropathy:	☐Loss of feeling in:	☐Hands	☐Feet	☐Numbness	☐
☐Neurologic:	☐Seizures ☐Dizziness	☐Headaches	☐Memory loss	☐Uneasy gait	☐
☐Psychologic:	☐Sleep disturbance	☐Hallucinations	☐Frequent anxiety	☐Depression	☐
☐Blood:	☐Bleeding/bruising	☐Swollen lymph nodes	☐Blood clots	☐Anemia	☐
☐Non-Drug Allergies:	☐Foods	☐Seasonal	☐Other:		☐
☐Description/Other:					

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____

_____

_____

Where did your accident/injury occur? _____

_____

_____

How did your accident/injury occur? _____

_____

_____

Will this accident/injury involve litigation currently or in the future? _____

_____

_____

☐ My visit is not related to a motor vehicle accident, work-related injury, school injury, or any other injury for which another party is responsible.

Signature: _____ Date: _____

Thank you for your assistance.

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, test results, medication dosage changes, and billing/collection/claims information.
This information may be released to:

☐ Spouse/Name: _____
☐ Child(ren)/Name(s): _____
☐ Other: _____
☐ Information should not be released to anyone but me.

Messages

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

☐ You can leave a detailed message.
☐ Please leave a message asking me to return your call.
☐ Don't leave messages on my voicemail.

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

E-mail Messages/Portal

☐ Use my email or portal contact to send messages for me to contact the nurse for information.
☐ Use my email or portal contact to leave detailed messages and information.
☐ Attach lab results to the email/portal message.
My email address is: _____

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

Signature:_____ Date: _____

Witness:_____ Date: _____