Orthopedic Specialists of San Diego

5555 Reservoir Dr, Ste 104, San Diego CA 92120

Office (619) 286-9480
Fax (619) 286-4568

PATIENT INFORMATION

Last Name, First:			Home Phone:
Address:			Work Phone:
City/State/Zip:			Cell Phone:
Birthdate:	SSN:	Male / Female	Driver's License. No:
Marital Status: ☐Married ☐Single ☐Divorced ☐Widow		Email:	

RACE: *Please check one (2012 US Federal Gov't. Requirement)*
☐African American ☐Caucasian ☐Chinese ☐Filipino ☐Japanese ☐Native American
☐Native Hawaiian ☐Pacific Islander ☐ Middle Eastern ☐Refused ☐Other:

ETHNICITY:
☐Hispanic ☐Non-Hispanic
☐Refused

Employer:		Phone:
Address:		Job Title:
Date of Injury:	Work Related: YES / NO	Auto Accident: YES / NO

Reason for your visit: ☐ Consult ☐Worker's Compensation ☐ Motor Vehicle Accident ☐ Litigation ☐ Other:

Claims Adjuster:	Claim No.	Attorney:
Referring Physician:		Phone:
Primary Physician:		Phone:
Cardiologist:		Phone:

PHARMACY

CA Bill AB2789 mandates all prescriptions be transmitted electronically. Please provide your pharmacy of choice.

Pharmacy Name & Address:	Phone:

PRIMARY INSURANCE	SECONDARY INSURANCE
Company	Company
Policy/ID#	Policy/ID#
Group #	Group #
Cardholder's Name	Cardholder's Name
Relation to patient	Relation to patient

AUTHORIZATION FOR TREATMENT OF MINOR (If patient under 18years of age)

Parent/Guardian Signature

Relationship:	SSN:	Printed Name:

TREATMENT/PAYMENT AGREEMENT FOR ORTHOPEDIC SPECIALISTS OF SAN DIEGO

The preceding information is true to the best of my knowledge. I authorize release of any medical or other information necessary to process claims and for payment of assigned medical benefits for my medical services to Orthopedic Specialists of San Diego. I agree that I am ultimately responsible for my account regardless of insurance coverage. I understand that my personal medical insurance will not be billed, if my injuries result from a motor vehicle accident, work injury, or other liable accident. I acknowledge that finance charges will be added to accounts unpaid after 90 days at 1% per month and that I will be responsible for collection and legal costs involved in collections. Should OSSD consider it appropriate to assign my account to a collection agency, a 10% additional charge will be added to the principle.

Signature	Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY OF PRACTICE

I hereby acknowledge that I was offered to review a posting of the Notice of Privacy Practices of this medical office on the website of **sdorthopedics.com**. 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 as any amendments are made.

SIGNED: _____ DATE: _____

PRINT NAME: _____

If not signed by the patient, please indicate:
Relationship: □ Parent or guardian or minor patient
□ Guardian or conservator of an incompetent patient
□ Beneficiary or personal representative of deceased patient

NAME OF PATIENT: _____

IN CASE OF EMERGENCY CONTACT:

Name:_____ PHONE:_____ RELATIONSHIP:_____

NOTIFICATION PREFERENCES

I request the use of the following methods of communication of information related to my personal health information, treatment, or payment for treatment. I acknowledge that I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

PREFERENCE OF COMMUNICATION: ☐ Phone ☐ Mail ☐ Email (Please select all that apply.)

☐ **Phone**:_____ (cell / home / work)

May we leave detailed messages concerning results of laboratory work, other diagnostic testing, or referrals to other providers on your answering machine or with someone in your household?

☐ NO ☐ Yes: Name & relationship: _____

☐ **Mail**: You may contact me at the address provided on the registration paperwork.

☐ **E-mail**:_____

Not all physicians and/or staff have access to e-mail for the purpose of communicating with patients. By providing your e-mail address, you are authorizing our physicians and/or staff to communicate with you by e-mail knowing the content of which may include protected health information which security cannot be guaranteed. You agree that we are not responsible for the interception of those messages by others. _____ Initial

SIGNED: _____ DATE: _____

_____ Initials

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill.

_____ Initials

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived.

_____ Initials

Checks: Returned checks may be subject to a $30.00 fee.

_____ Initials

Missed Appointments: Please note a $25.00 fee may be charged for a missed appointment or failure to cancel without 24-hour notice. This fee will be directly billed to you.

_____ Initials

Claims Submission: As a courtesy, Orthopedic Specialists of San Diego will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims, however, payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's policy guidelines. If we receive notification that you are not eligible for coverage, or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of billing. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency.

_____ Initials

Surgery: If surgery becomes necessary, I understand most cases require a surgery deposit to be collected to reserve my surgery date. Any unused portions will be refunded post-surgery.

_____ Initials

Ancillary Services: Laboratory, durable medical equipment (DME), hospitals and outpatient radiology procedures will be billed separately by an outside provider. Please contact them directly with any questions regarding your bill.

_____ Initials

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Orthopedic Specialists of San Diego for all service rendered.

I have read and understand the above statements.

I agree to comply with the financial policies of Orthopedic Specialists of San Diego and I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____

Patient or Guardian Signature Date

_____ _____

Patient Name (please print) Date of Birth

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MEDICAL HISTORY

Last, First Name:			DOB:
Age:	Height:	Weight:	Circle One: RIGHT LEFT Handed
Primary Physician:			

History of Present Illness, Injury or Complaint

Reason for Visit:		Work Related: YES NO If YES, date last worked: Claim No.:
Date of Onset of Illness/Injury (or Approx Mo/Yr):		
Is injury related to MVA (Motor Vehicle Accident)? □ YES □ NO	If YES, date of accident:	Litigation (lawsuit) involved: □ YES □ NO

PRESENT MEDICAL INFORMATION What body part is involved? (Please check all that apply)

Ankle:	□ R	□ L	Arm:	□ R	□ L	Back:	□ R	□ L	Elbow:	□ R	□ L
Finger:	□ R	□ L	Foot:	□ R	□ L	Hand:	□ R	□ L	Hip:	□ R	□ L
Knee:	□ R	□ L	Leg:	□ R	□ L	Neck:	□ R	□ L	Pelvis:	□ R	□ L
Shoulder:	□ R	□ L	Toe:	□ R	□ L	Wrist:	□ R	□ L	Other:		

How long ago did the problem begin? number of □ days □ weeks □ months □ years

Have you been seen in the ER? □ YES □ NO If YES, Where:

On a scale of 0-10 (10 being worst), how severe is your pain?
What is the quality of your pain? □ Sharp □ Dull □ Stabbing □ Throbbing □ Aching □ Burning

SOCIAL HISTORY

Do you smoke? YES NO	If yes, duration (yrs.)?	Packs/cigars per day:	If quit, when?
Alcohol consumption? YES NO	If yes, frequency:	Any other drug of substance abuse?	

MEDICAL HISTORY – FAMILY (Major medical **illness** of PARENTS & SIBLINGS only; specify relationship.)

1.	5.
2.	6.
3.	7.
4.	8.

MEDICAL HISTORY - SELF (Major medical **illnesses**. Please continue on back if necessary.)

1.	5.
2.	6.
3.	7.
4.	8.

SURGICAL HISTORY - SELF (Provide approx. dates. Please continue on back if necessary.)

1.	5.
2.	6.
3.	7.
4.	8.

Please ✓ symptoms you currently have or have had in the PAST YEAR.

Constitutional
□ Fevers or Chills
□ Fatigue

Eye, ear, nose and/or throat
□ Double Vision
□ Ringing in Ears
□ Trouble Swallowing
□ Difficulty hearing
□ Blurred vision
□ Nose bleed
□ Sore throat
□ Sinus problems
□ Glaucoma
□ Dental problems / cavities

Cardiovascular
□ Chest pain
□ Dizziness
□ High blood pressure
□ High cholesterol
□ Irregular heart beat
□ Heart attack

Integument
□ Rashes
□ Skin Sores

Respiratory
□ Shortness of breath
□ Pneumonia
□ Cough
□ Tracheotomy

Gastrointestinal
□ Ulcers
□ Poor appetite
□ Crohn's disease / colitis
□ Constipation
□ Diarrhea
□ Hiatal hernia
□ Hemorrhoids
□ Blood in stool
□ Ulcerative colitis
□ Reflux
□ Irritable bowel syndrome

Genitourinary
□ Surgical problems
□ Blood in urine
□ High PSA
□ Urgency
□ Frequent urination
□ Unable to get erections
□ Urinary tract infection
□ Enlarged prostate

Neurological
□ Seizures
□ Strokes
□ Memory loss
□ Weakness in arms or legs
□ Spasticity
□ Poor balance

Psychiatric
□ Anxiety
□ Depression
□ Thoughts of suicide

Endocrine
□ Thyroid disease
□ Diabetes
□ Osteoporosis

Hematologic
□ Vascular disease
□ Bruising
□ Enlarged lymph nodes
□ Bleeding
□ Anemia

Musculoskeletal
□ Back pain
□ Swollen ankles
□ Swollen joints
□ Gout

Immunological
□ Fevers
□ Chills
□ Night sweats
□ Eczema
□ Hay Fever
□ Asthma

Do you use:
□ Brace or prostheses
□ Contact Lenses
□ Dentures
□ Glasses
□ Hearing Aides

Do you have?
□ Claustrophobia
□ Metal in your body
□ A pacemaker
□ Tuberculosis

Date of last tetanus shot?

MEDICATIONS (Please use back of page if necessary)			
	Prescriptions AND Over-the-counter medications	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

MEDICINAL ALLERGIES Please list any known allergies and briefly describe the reaction:		
	Allergy	Reaction
1.		
2.		
3.		
4.		

Reviewed by:	Date:
Patient/Guardian Signature:	Date: