



**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: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		Email:	

<b>RACE:</b> Please check one (2012 US Federal Gov't. Requirement) <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Refused <input type="checkbox"/> Other:		<b>ETHNICITY:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refused
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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:
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Referring Physician:	Phone:
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Primary Physician:	Phone:
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Cardiologist:	Phone:
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**PHARMACY**

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

Pharmacy Name & Address:	Phone:
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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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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/guardian of minor patient  
 Guardian or conservator of an incompetent patient  Beneficiary or personal legal representative (with documentation).

NAME OF PATIENT: \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**COMMUNICATION 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:  No  Yes

May we communicate with the following individuals in your household about your medical record?

No  Yes Name & relationship: \_\_\_\_\_

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 any person or entity. \_\_\_\_\_ Initial

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

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.

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.

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

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.

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.

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.

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.

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.

Debt: 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.

Fee Policies: If your account becomes delinquent (past due), we may take the following actions: (1) refer your account to a collection agency, (2) file a lawsuit to recover the amount owed. If your account is referred to a collection agency, you agree to pay a collection fee and interest at an annual rate of 10% on the unpaid balance, beginning 30 days after the date of service. If legal action is required to collect the amount owed, you agree to pay all reasonable attorney's fees and court costs incurred in the collection process, in addition to the outstanding balance, collection fees, and interest.

Understanding: 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.

Consent: I agree that, in order for Alvarado Orthopedic Medical Group Inc, DBA Orthopedic Specialists of San Diego, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Alvarado Orthopedic Medical Group Inc, DBA Orthopedic Specialists of San Diego, or EBO Servicer and collection agents may contact me by telephone or text message at any telephone number I have provided (without limitation of wireless) or Alvarado Orthopedic Medical Group Inc, DBA Orthopedic Specialists of San Diego or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

By providing my email address, I understand and agree to receive communications by email from Alvarado Orthopedic Medical Group Inc, DBA Orthopedic Specialists of San Diego, and collections agents to service my account or to collect any amounts I may owe. I understand that work or government email addresses may be monitored by third parties, and if I do not provide a personal email address, I consent to any potential third-party disclosure of my information. I have read and understand the above statements.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Mobile Number



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

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

<b>Date of last tetanus shot?</b>
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<b>MEDICATIONS</b> (Please use back of page if necessary)		
Prescriptions AND Over-the-counter medications	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
<b>MEDICINAL ALLERGIES</b> Please list any known allergies and briefly describe the reaction:		
Allergy	Reaction	
1.		
2.		
3.		
4.		
Reviewed by:	Date:	
Patient/Guardian Signature:	Date:	



**INTRODUCTION:**

I, the undersigned patient, hereby consent to the use of Artificial intelligence (AI) scribe dictation technology in the documentation of my medical records at Alvarado orthopedic medical group Inc, DBA Orthopedic specialists of San Diego. This form provides information about the use of AI technology, its purposes, and the security measures in place to protect my privacy.

**PURPOSE OF AI DICTATION:**

AI scribe dictation technology is utilized to convert spoken words into text format for the purpose of documenting medical information in an efficient and accurate manner. The AI system may be employed in the transcription of medical notes, reports, and other relevant documents.

**HOW AI DICTATION WORKS:**

During my medical appointments, any verbal information provided by me or my healthcare provider may be recorded using AI scribe dictation. The AI system processes and transcribes spoken words into text, contributing to the creation of my medical records. The AI scribe will not be used to make any decisions about your care. Your doctor will review all of the information in your medical record, including the AI-scribed notes, before making any decisions about your care.

**SECURITY MEASURES:**

The medical practice employs robust security measures to safeguard the confidentiality and integrity of the information processed through AI dictation. These measures include encryption, access controls, and regular security audits to prevent unauthorized access and protect against data breaches.

**PATIENT RIGHTS:**

1. Access to Information: I have the right to request access to my medical records and transcripts generated through AI dictation.
2. Amendment of Information: I have the right to request corrections or amendments to any inaccuracies in my medical records.
3. Withdrawal of Consent: I have the right to withdraw my consent for the use of AI dictation at any time. However, withdrawal may affect the efficiency of medical record documentation.

**BENEFITS AND RISKS:**

Benefits:

- Increased efficiency in medical record documentation
- Enhanced accuracy in transcribing verbal information.

Risks:

- Possibility of errors in transcription.
- Potential limitations in recognizing certain accents or speech patterns.

**PATIENT CONSENT:**

I have read and understand the information provided in this consent form. I have had the opportunity to ask questions, and any concerns have been addressed to my satisfaction. By signing below, I voluntarily consent to the use of AI dictation technology in the creation of my medical records at Alvarado orthopedic medical group Inc, DBA Orthopedic specialists of San Diego.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date of Birth



Dear Patient:

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to help us in the following ways:

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don’t reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician’s goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician’s office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment. Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date of Birth