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.

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 cash patient 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 _____

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SPORTS MEDICINE HEALTH QUESTIONNAIRE

Dr. Scott P. Fischer

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 _____

When did the injury occur?

How 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
☐ other infections
_____

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**
☐ Penicillin
☐ Adhesive Tape
☐ Nickel or Metal Allergy (please specify) _____
☐ Codeine
☐ Sulfa
☐ Latex
☐ Morphine
☐ Aspirin
☐ Iodine
☐ Cheap Metal Allergy: _____
☐ Demerol
☐ NSAID's
☐ 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
- ☐ Irregular heart beat

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)
- ☐ Severe Neck stiffness

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						
Blood Clots/ Disorders						
Other (please specify)						

Primary Care Physician: _____

Telephone #:_____ City: _____

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

Cardiologist: _____

Telephone #:_____ City: _____

Other: _____

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 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:

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

[ ] Spouse/Name: _____

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

[ ] Other: _____

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 voice mail.

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: _____

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

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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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