

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) Married Single Divorced Widowed			Primary Care Physician		
	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? NO YES	If yes, Where did your injury occur? 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 <input type="checkbox"/> Patient <input type="checkbox"/> 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

New Spine Patient Questionnaire

Name: _____ Primary Dr. Address: _____
 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: _____ Time 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)?
 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)?
 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/where/how often did you go? _____

Are you currently working? no yes what type of work? _____
 full duty modified duty: _____

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

New Spine Patient Medical and Surgical History

Past Medical History

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

New 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)

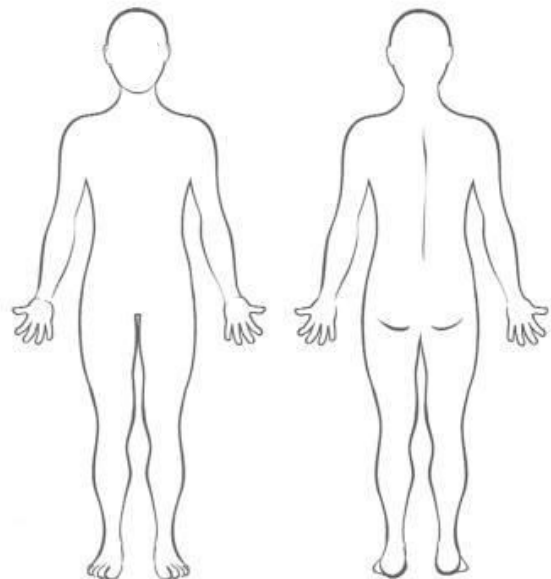
none apply

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

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.



New Spine Patient Medical and Surgical History

Review of Systems

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

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: _____



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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PHYSICAL MEDICINE AND REHABILITATION · ADULT AND PEDIATRIC SPINE SURGERY · HAND AND UPPER EXTREMITY SURGERY · FOOT AND ANKLE SURGERY

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CONSENT FOR TREATMENT – NOTICE OF POLICIES

I hereby consent and authorize Orthopaedic Specialty Institute Medical Group of Orange County (OSI) healthcare providers to perform medical care, diagnostic tests, surgical care and other therapeutic measures, as may be indicated for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), healthcare provider(s), medical staff, and the company, of all responsibility resulting from my action.

I also authorize OSI, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payers (including but not exclusive of, private insurance, Medi-Cal, Medicare, Tricare, Work-Comp, etc.)

I acknowledge that I have been given the ability to review OSI's policies including Financial Policy.

FINANCIAL POLICY

- We will submit claims to your insurance company for all medical services rendered at OSI. Any other services related to your medical care not rendered at OSI (i.e. laboratory, pathology, hospital fees, outpatient surgery center fees, anesthesiologist, co-surgeon, etc.), will be billed by the entity providing those services. It is **your** responsibility to verify that OSI is part of your insurance plan. We will attempt to verify your eligibility and benefits with your insurance carrier; however, this does not guarantee that they will pay for the services provided, and you will remain financially responsible if they do not provide payment.
- **OSI accepts the following insurance plans:**
 - **Medicare** – pays 80% after the deductible has been met. We will bill your coinsurance for the remaining 20% as a courtesy; however, you are responsible for the 20% coinsurance of the Medicare allowable amount.
 - **Contracted PPOs and HMOs** – you are responsible for the payment of co-pay and deductible at the time of the service, as well as for any charges for which you failed to secure prior authorization (if necessary).
 - **Non-Contracted PPOs** – you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
 - **Self-Pay** (uninsured) - you are expected to pay in full at the time of the service.
 - **Worker's Compensation** – you are not responsible for any charges unless the case has been dismissed or denied.

- **Personal Injury/Motor Vehicle Accidents** - you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
- **Surgery Deposits** – once the decision for surgery is made, our surgery coordinator will contact your insurance carrier to confirm eligibility benefits and obtain authorization. The surgery coordinator will provide you with an estimated cost of your surgery. This amount will be collected as a deposit at or before the time of your pre-operative appointment.
- **Medical Records** – all medical records requests are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).
- **Divorce Related** – the parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all, or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.
- **Bad Debt** - patients who do not pay bills within 90 (ninety) days of the statement date, will be referred to a collections agency, and **may be discharged from the practice for non-payment.**
- **Failed Appointment Charge for MRI** – we reserve the right to charge \$25 (twenty-five) for each failed appointment not canceled at least 24 hours before the scheduled appointment time. This charge is not covered by your insurance.
- **Usual and Customary Rates** - our practice is committed to the best treatment for our patients. Our charges are considered usual and customary for our area. You are responsible for payment, regardless of any insurance company’s arbitrary determination of usual and customary charges.
- **Financial Responsibility** – based on our contractual agreements with the insurance companies and our internal policies, we are informing you of the following:
 - Your health insurance deductibles and any expenses deemed not covered by your insurance company will be your financial responsibility.
 - All monies owed by you, such as office visits co-payments and non-covered services or supplies, are due at the time of the service.
 - If you are not prepared to pay any amounts due at the time of the visit, you will be asked to re-schedule the appointment, unless the physician determines that your medical condition prohibits this.
- **Method of Payment** - our office accepts the following forms of payment: credit cards, cash, money order, and checks. A \$25 (twenty-five dollar) service charge will be assessed to your account for any returned check by your bank. This charge is not covered by your insurance.

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.

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose 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)	