Orthopaedic Associates of Southern California

14642 Newport Ave #105 Tustin CA 92780
145 S. Chaparral CT#101 Anaheim, CA 92808
11180 Warner Ave #161 Fountain Valley, CA 92708
Phone: 949-688-0958 **Fax**: 949-688-0960

PATIENT INFORMATION

Patient Name:_____ **Date of Birth**: _____
Last name, First name

Sex: ☐ M ☐ F **SSN:** _____ **Marital Status**: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Street Address:_____ **APT#:**_____
City:_____ **State:**_____ **Zip Code**: _____
Primary Phone #:_____ **Secondary Phone #:** _____

Email: _____

Emergency Contact_____ **Relationship:** _____
Phone number: _____

Occupation:_____ **Employer**: _____

Family Doctor:_____ **Phone:** _____

Pharmacy:_____ **Phone**: _____

MEDICAL HISTORY

Chief Complaint: _____

_____

_____

Medical History: Please mark the conditions that apply to you

	None		**Hypertension**
	Heat Failure		**Diabetes**
	Seizure		**COPD**
	GI/GU		**Physical Handicap**
	Prosthetic Device		**Heart Disease**
	Cerebrovascular Accident		**Renal**
	Cancer		**Psych**
	GERD		**Other:**

Review of the systems: mark all that apply.

	HEENT		**CVS/Respiratory**		**Gastrointestinal**		**Skin/Muscular**		**Genito- Urinary**
	Blurry vision		Cough		Abdominal Pain		Skin Rash		Problem urinating
	Sore throat		Sputum		Nausea/Vomiting		Back Pain		Abdominal Discharge
	Nasal Drainage		Chest Pain		Diarrhea		Upper Extremities pain		
			Trouble Breathing				Lower Extremities pain		

Medication/ Allergies

Please let the office know if you need additional space for medication list.

Medication	Dose/amount	How Often

Please list allergies and reactions to any medication you have had in the past including food allergies.

Medication Allergies	Reaction

1. Are you a loud, habitual snorer, disturbing your bedroom companion? ☐ Yes ☐ No
2. Do you feel tired and groggy on awakening? ☐ Yes ☐ No
3. Do you experience sleepiness and fatigue during waking hours? ☐ Yes ☐ No
4. Have you been observed to choke/ hold your breath during your sleep? ☐ Yes ☐ No
5. Are you taking, or ever taken steroid medication? ☐ Yes ☐ No
6. Do you use/smoke any mood altering or recreational substance? ☐ Yes ☐ No
7. Have you had a fever, sore throat or any cold in the last week? ☐ Yes ☐ No

   If yes, describe briefly: _____
8. Do you have any loose teeth, dentures, partial plates or crowns? ☐ Yes ☐ No
9. Have you ever smoked cigarettes? ☐ Yes ☐ No

   If yes, how many packs a day? For how long?_____ if you stopped, when did you quit? _____
10. Do you drink alcoholic beverages? ☐ Yes ☐ No

Patient Name: _____

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

ANESTHESIOLOGIST QUESTIONNAIRE

Please read the following and mark all that apply to you. The information obtained will greatly assist your anesthesiologist in planning the safest and most pleasant anesthetic to use. If the answer to any of these questions none, please mark NONE.

	Lung Problems ☐ **NONE**		**Heart Problems** ☐ **NONE**		**Bleeding Problems** ☐ **NONE**			**Other** ☐ **NONE**
	Bronchitis		Heart attack		Brain Disease/Strokes			Kidney Problems
	Emphysema		Heart murmur		Epilepsy/ Seizures			Liver Problems
	Asthma		Chest Pain/Angina		Nervous system problems			Hepatitis
	Wheezing		Heart failure		Thyroid Problems			
			Palpitations/ Arrythmia		Diabetes			
			High Blood Pressure		Muscle Disease/ Arthritis			
			Other Heart Problems		Cancer			
					Sleep Apnea			

Please list any previous Operations/ Surgeries/Anesthetics (including anesthesia at dental offices):

Operation	Date	Type of Anesthesia	Problems (if any)

List any other HOSPITALIZATIONS NOT included above.

1. _____
2. _____
3. _____

Has any blood relative ever had difficulty or problem with anesthetics (e.g., Malignant Hyperthermia)?

☐ Yes ☐ No If yes, describe briefly: _____

_____

_____

Patient name: _____ Date of birth: _____

ASSIGNMENT OF BENEFITS

I/We do hereby consent to and authorize the performance of all treatment, surgery and medical services by the staff of Orthopaedic Associates of Southern California which they may deem advisable. I hereby certify that to the best of my knowledge, all statements contained hereon are true. I also hereby authorize Orthopaedic Associates of Southern California to release information requested by the insurance company and/or its representative. I hereby agree to assign all benefits payable by my insurance company to my provider, Orthopaedic Associates of Southern California

_____I fully understand the agreement and consent will continue until cancelled by me in writing.

_____I authorize Orthopaedic Associates of Southern California to render necessary medical or surgical treatment to the above- named minor of whom I am the parent or legal guardian.

FINANCIAL AGREEMENT

I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract. I hereby agree to pay the interest rate of 10% per annum for all outstanding charges incurred for medical services for myself and my dependents. I furthermore agree to pay legal expenses including court cost and reasonable attorney's fee, collection agency expense, and all expenses incurred to collect an amount I may owe as allowed by the state and federal laws. Because my provider is billing my insurance as a courtesy and for this reason, I may incur debt to my provider, I hereby authorize the verification of my employment in the event that I do incur debt to my provider.

_____	_____	_____
Signature of Patient/Guarantor	Print Name	Date
_____	_____	_____
Signature of Guarantor (If patient is a minor)	Print Name	Date

Cancellation Fee Schedule

Missed appointments without prior or late notification translates to missed revenue for any provider. Frequently missed appointments result to significant financial loss to any provider. Orthopaedic Associates of Southern California reserves the right to terminate medical services and/or the right to charge a fee for any scheduled visits to patients who:

1. Cancelled with less than 24-hour notice.
2. Missed the appointment without calling to cancel (no show).
3. Patients who are 15 minutes late or more will have to reschedule and will be considered a no show.

Other Office Fees

Orthopaedic Associates of Southern California. requires payment for the completion of forms or letters. A charge of $25 **per form** is due at the time of pick up. By signing below, I attest that I have read and understood the agreement and policy above.

_____	_____
Patient/Guarantor Signature	Date

Patient Consent for use and Disclosure of Protected Health Information (PHI)

I hereby give my consent for Orthopaedic Associates of Southern California to use and disclose protected health information about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided by Orthopaedic Associates of Southern California describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Orthopaedic Associates of Southern California reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Orthopaedic Associates of Southern California
14642 Newport Ave Suite 105 Tustin CA, 92780
Phone: (949) 688-0958 Fax: (949) 688-0960

With this consent Orthopaedic Associates of Southern California may call my home or other alternative location and leave a message or voicemail or in person in reference to any items that assist the practice in carrying out my treatment, payment of health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Orthopaedic Associates of Southern California may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment or health care operations, such as appointment reminder cards and patient statements. I have the right to request that Orthopaedic Associates of Southern California restrict how it uses or discloses my protected health information to carry out treatment, payment or health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Orthopaedic Associates of Southern California to use and disclose my protected health information to carry out treatment, payment or health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Orthopaedic Associates of Southern California may decline to provide treatment to me.

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

_____ _____

Print Patient's Name Parent/Legal Guardian Name (if applicable)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF ORTHOPAEDIC ASSOCIATES OF SOUTHERN CALIFORNIA

By signing this document, I acknowledge that I have been provided a copy of the Notice of Privacy Practices. This notice explains how my personal information can be used and disclosed by this medical office.

Printed Patient's Name: _____

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date