ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

# PATIENT REGISTRATION FORM

**PATIENT INFORMATION:** (Please use full legal name, no nicknames)

| | | | | |
|---|---|---|---|---|
| Last Name: | First Name: | | Middle Initial: | Verified by: |
| Date of Birth: | Age: | Sex: | Social Security #: | |
| Address: | | | Apt/Unit #: | |
| City: | | State: | Zip: | |
| Home Phone #: | Cell Phone #: | Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed | | |
| E-mail Address: | | | Driver's License #: | |
| Was this an injury? ☐ Yes ☐ No | If yes, where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School | | Date of injury: | |
| Employer Name: | Occupation/Title/Position: | | | |
| Employer Address and Phone #: | | | | |
| Emergency Contact Name: | Relationship: | Phone #: | | |

**GUARANTOR INFORMATION:** (List person or insured name responsible for bill – use full legal name, no nicknames)

| | | | | |
|---|---|---|---|---|
| Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other | | | | Verified by: |
| Last Name: | First Name: | | Middle Initial: | |
| Date of Birth: | Age: | Sex: | Social Security #: | |
| Address: | | | | |
| City: | | State: | Zip: | |
| Home Phone #: | Cell Phone #: | | | |
| Employer Name: | Occupation/Title/Position: | | | |
| Employer Address and Phone #: | | | | |

**INSURANCE INFORMATION:** (Please allow receptionist to photocopy your insurance ID cards)

***IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS***

| | | | | | |
|---|---|---|---|---|---|
| **PRIMARY INS** | Insurance Company: | | Copay: | ☐ HMO ☐ PPO ☐ POS | Verified by: |
| | Policy/ID #: | | Group #: | | |
| | Claims Address & Phone #: | | | | |
| | Insured's Name: | Relationship: | | Insured's Date of Birth: | |
| | Insured's Employer: | Insured's Social Security #: | | | |
| **SECONDARY INS** | Insurance Company: | | Copay: | ☐ HMO ☐ PPO ☐ POS | |
| | Policy/ID #: | | Group #: | | |
| | Claims Address & Phone #: | | | | |
| | Insured's Name: | Relationship: | | Insured's Date of Birth: | |
| | Insured's Employer: | Insured's Social Security #: | | | |

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 PATIENT HISTORY

NAME _____ DATE _____ AGE _____

DATE OF BIRTH _____ HEIGHT _____ft _____in WEIGHT _____lb

OCCUPATION: _____ SINGLE MARRIED RETIRED EMPLOYED

WHO REFERRED YOU TO THIS OFFICE? _____

INTERNIST/PCP _____ CARDIOLOGIST _____

OTHER SPECIALIST(S) _____

REASON FOR YOUR VISIT _____ LEFT / RIGHT / BOTH

DURATION OF SYMPTOMS_____ MONTHS _____ YEARS

What make is better? _____

What makes it worse?_____

Have you had any of the following?

☐Steroid Injections Last injection _____ How many? _____

☐Viscosupplementation Injections (Synvisc, Orthovisc, Euflexxa, etc) Last injection_____ How many? _____

☐Bracing _____

☐Physical Therapy How long? _____

☐Anti-Inflammatory Medications (past & present – Aleve, Advil, Ibuprofen, etc)_____

**PAIN RATING:**

☐Mild ☐Moderate ☐Severe ☐Disabling Daily pain level (1-10) _____

*Pain at night?* ☐ Y ☐N *Back pain?* ☐ Y ☐ N

**DO YOU LIMP?**

☐Slightly ☐Mildly ☐Moderately ☐Severely ☐Unable to walk

**DO YOU REQUIRE ASSISTANCE?**

☐None ☐Cane at Times ☐Cane Full Time ☐Walker ☐Wheelchair

**HOW FAR CAN YOU WALK?**

☐Unlimited ☐6 Blocks ☐2-3 Blocks ☐Indoor Only ☐ Unable

**CAN YOU CLIMB STAIRS?**

☐Normally ☐Normally with the rail ☐Any Method ☐Unable

**CAN YOU PUT ON SOCKS AND SHOES?**

☐With Ease ☐With Difficulty ☐Unable

**WHAT IS YOUR ACTIVITY LEVEL?**

☐Bedridden ☐Sedentary ☐Semi-Sedentary ☐Light Labor ☐Moderate Labor ☐Heavy Labor

**PAST MEDICAL HISTORY**

Have you experienced or been told by a doctor that you have any of the following conditions? ☐ None

| | | |
|---|---|---|
| ☐ Anemia | ☐ Aneurysm | ☐ Cardiac Arrhythmia |
| ☐ Blood Clots | ☐ Carotid Artery Disease | ☐ Congestive Heart Failure |
| ☐ Cardiac Disease | ☐ Lung Disease (Emphysema) | ☐ Diabetes |
| ☐ Gastrointestinal Bleeding | ☐ GERD/Reflux | ☐ Hypothyroidism |
| ☐ Heart Valve Disease | ☐ High Cholesterol | ☐ High Blood Pressure |
| ☐ Kidney Disease | ☐ Peptic Ulcer Disease | ☐ Peripheral Vascular Disease |
| ☐ Stroke/TIA | ☐ Osteoporosis | ☐ Methicillin Resistant Staph Aureaus (MRSA) |
| ☐ Other Conditions_____ | | Infection_____ (body part) |

**DENTAL HISTORY**

☐ Dentures ☐ Dental Implants ☐ Gum Disease ☐ None

Most recent dental appointment (mo/year) _____

**PAST SURGICAL TREATMENT** (List surgical procedures and year performed) ☐ None

_____

_____

_____

**MEDICATION** (List dosage and frequency taken. Attach list if applicable) ☐ None

_____

_____

**ALLERGIES** ☐ None

_____

Allergy to Metal, Nickel, or Jewelry? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No Amount:_____

Do you drink alcohol? ☐ Yes ☐ No Amount:_____

**PHARMACY NAME:** _____ **PHONE:** (____)_____**CITY:**_____

Interests/Hobbies:_____

**REVIEW OF SYSTEMS**

Have you experienced any of the following within the past 6 months?

| | | | |
|---|---|---|---|
| ☐ Weight Loss | ☐ Fever/Chills/Sweats | ☐ Bleeding Tendencies | ☐ Chest Pain |
| ☐ Weight Gain | ☐ Shortness of Breath | ☐ Bruising | ☐ Irregular Heart Beat |
| ☐ Back Pain | ☐ Headache | ☐ Painful Urination | ☐ Abdominal Pain |
| ☐ Numbness/Tingling | ☐ Cough | ☐ Urinary Frequency | ☐ Leg Swelling |
| ☐ Weakness | ☐ Wheezing | ☐ UTIs | |
| ☐ Vision Changes | ☐ Recent Cold/Flu | ☐ Nausea/Vomiting | |

ORTHOPAEDIC
SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

**Accident/Injury Information Form**

Name: _____ Doctor:_____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____
_____
_____

Where did your accident/injury occur? _____
_____
_____

How did your accident/injury occur? _____
_____
_____

Signature: _____ Date: _____

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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**:

[ ] 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: _____

ORTHOPAEDIC SPECIALTY INSTITUTE
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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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# 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.



Initials_____

- **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)



Initials_____