Oceanside Office: 3905 Waring Road, Oceanside, CA 92056
Carlsbad Office: 6121 Paseo Del Norte, Ste. 200, Carlsbad, CA 92011
Vista Office: 1958 Via Centre Drive, Vista, CA 92081
Ph: 760-724-9000 Fax: 760-724-3686 | www.orthonorthcounty.com

Patient Information

Chart: ____________________

Patient name: ______________________________ Date: ______________
Address: ______________________________ Ph: ______________
City: ______________ State ____ Zip ________ Cell: ______________
Email address: ______________________________ Birthdate: ______________
Family physician: ______________ Referring physician: ______________
Sex: M F (circle one) Referring source (name) ______________
SSN: ______________ Marital status: __________ Drivers license: ______________
Any previous names: ______________
Employer name: ______________ Occupation: ______________
Employer address: ______________ Work ph: ______________
City ______________ State ______________ Zip __________
Emergency contact: ______________ Ph: ______________

Person responsible for payment: Self: ______________________________
Address: ______________ City: ______________ State: ______ Zip: __________
Home phn: ______________ Work phone: ______________
1st Ins. company: ______________ Name of insured: ______________
SSN of insured : ______________ Birthdate of the insured: ______________
Address: ______________ City ______________ State __________ Zip __________

Employer: ______________ Ins. ID# ______________ Group# __________
2nd Insurance co. ______________ Name of insured: __________ Group# __________
SSN of Insured: ______________ Birthdate of insured: ______/ ______/ ______
Address: ______________________________

Employer: ______________ Ins. ID# ______________ Group # ______________

I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Orthopaedic Specialists of North County, A Medical Group, Inc. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Orthopaedic Specialists of North County, a Medical Group, Inc. in the event of account delinquency, all amounts due including, but not limited to, reasonable attorney's fees.
I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Orthopaedic Specialists of North County, a Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release of all information necessary to secure payment.
I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party payer or because of pending legal claims.

Date: ______________ Responsible party: ______________________________

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Name:____________________________**DOB:**__________________________**Acct.#:**__________________________**Chart#:**__________________________

Patient Consent for Treatment / Release of Information / Communication Authorization

TO OUR PATIENTS: Before you begin treatment at Orthopaedic Specialists of North County (ONSC), the law requires that we explain your rights and responsibilities while a patient at OSNC. If you have a complaint or concern about your care, please discuss it with your provider or a manager. If your concern remains unresolved, you may call the privacy officer, Barritt Burke at 760 477-2104. Please read and sign the sign below. We will, unless you object, do the following and use communications like post cards, telephone, about your appointments, email, faxing, paging, email voice messaging to reach you, alert you, and leave you messages. Your signature at the bottom connotes agreement and understanding. We may also use a sign-in sheet at the front desk and ask that you sign your name. We have your permission to acquire your medication history: Initial _______

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, xrays, education or other diagnostic procedures. I understand that my Provider is available to explain the purpose of the procedures and treatment and that I have the right to refuse recommended treatment. My provider has my permission to secure any of my medical records for the purpose of treating me and communicate with my PCP or other medical providers as necessary. A record of my visit can be set to my referring physician. w will also communicate with any agency as provided by law, such as the CA State Workers Compensation Board, or employer in the case of Workers' Compensation injury. Initial ______

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW: I understand that it is important that medical providers have access to any of my medical records which will help them to safely treat me and manage my medical care. I agree and understand that a copy of my medical records including AIDS, HIV, Behavioral Health Service, Psychiatric Care, and treatment foe alcohol or drug use will be included as part of my health information for purposes of my medical care and for business operations. I also agree that OSNC can release my medical records to accrediting or regulatory agencies if those agencies request my records.
The following people may have access to my medical information at OSNC: Please list by relationship & name: i.e., wife; Jane Smith.

1) ____________________________2) ____________________________3) ____________________________

Others involved in your healthcare. We may disclose to a relative (or any other person you identify) your health information that directly relates to that person's involvement in your health care or who has responsibility for payment of your healthcare. We may also use or disclose your health information to notify or assist in notifying a relative or any other person responsible for your health care. We may also use or disclose your health information to notify or assist in notifying a relative or any person responsible for your care of your location, general condition.

PARTICIPATING INSURANCE / BILLING PROCESS / MEDICATE / MEDICAID ASSIGNMENT OF BENEFITS-PAYMENT OSNC MEDICAL BILLS. I request that payment of my bills by the "third payer" be made to OSNC on my behalf for any services furnished to me by or in OSNC. I assign the benefits payable for physician services to OSNC or physician furnishing the services. In consideration of office visits, I agree to pay OSNC for all the charges not covered by any third party payer. I have been provided a copy of the financial policy of OSNC. I understand I will be billed $50.00 for a "no show" appointment, and $25 processing charge for rebilling any charge not paid within a 30 day period. We will charge $35.00 NS fee for any 'bounced' check and $25 fee for co-pays which are not paid at the time of service and have to be billed. There is a fee for completing insurance forms not related to physician reimbursement. Initial _____

RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES: In many instances, a "third party payer" will pay a portion or all of my medical bills related to today's visit. In order for a "third party payer" to pay any or all of my bills related to today's visit at OSNC, I understand the "third party payer" may require information about the medical care and treatment I received. I authorize OSNC or its related entities to release to the "third party payer" any information needed to determine the payments related to the medical treatment I receive.

PATIENTS RIGHT TO PRIVACY: I acknowledge that I have been made aware of OSNC's privacy practices and HIPAA regulations which are posted in the reception area or website. I have been offered a copy of OSNC's notice of privacy practices to keep for myself.

AUTHORIZATON TO COMMUNICATE VIA EMAIL, ANSWERING MACHINE, ETC.: I authorize OSNC to leave messages about my Private Health information for me on my answering machine, email, or text if I have provided that information. We may leave messages on your answering machine or with an individual that answers your home phone; we may call your place of employment to give you information about your visit. We may schedule appointments for follow-up visits or diagnostic tests while you are at our check-out window. We may send post cards and other correspondents. I understand I have the right to revoke this consent, in writing, at any time except where Orthopaedic Specialists of North County has already made a disclosure in reliance on this content. This authorization expires 5 years from date noted unless withdrawn in writing.

I understand that if NO objections is noted above, I am giving my consent for ALL listed above.

____

Patient or authorized signature Date

OSNC
Orthopaedic Specialists of North County

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Medical Information

Chart: ____________________________

Form must be filled out before you see the physician. The information on the form provides basic information about your orthopedic problem and general health condition. This information is very important and can influence your orthopedic diagnosis and treatment.

Today's date:______________________Acct. #:_________________________Imaging: _____________________

Name ____________________________Sex: ___________Date of birth: _________________Age: _____________

Referring Doctor: ____

Height: ___________Weight: ____________Occupation: _________________________Dominant hand: R L

What type of orthopedic problems are you being seen for?____

Did your symptoms result from an accident? Yes __________No ___________If yes, list dates and nature of accident:

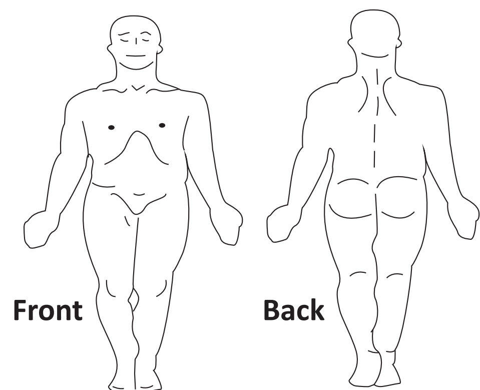
____

If no, when did your problem first occur: _________________________

Have you seen a doctor for this problem? Yes ____ No ___

Please rate your pain area on the diagram.

Mark 1 for most painful
Mark 2 for next most painful
Mark 3 for next most painful



How would you describe your symptoms (check all that apply)

☐ Dull ache ☐ Stiffness ☐ 'Giving out" ☐ "Sleepy" ☐ Cold
☐ Sharp ache ☐ Popping ☐ Hot ☐ Weak ☐ Stabbing ☐ Tingling
☐ Tingling ☐ Numb ☐ Cracking ☐ Cramping ☐ Chills

Check the severity of your symptoms:

☐ Mild no compromise of activities ☐ Slight, some compromise of activities
☐ Moderate, marked compromise of activities ☐ Severe—unable to perform activities

Has this been improving? ☐ Improving ☐ Getting worse ☐ Remaining unchanged

How frequent are the symptoms in this area?

☐ Occasional—less than half the day ☐ Intermittent—about half the day
☐ Frequent—more than half the day ☐ Constant—all day and every day

What relieves the symptoms? ____

What makes the symptoms worse? ____

Have you had similar problems before? ____

Medical Information (cont.)

Name:____ **Date:**____________________

Which medical tests or treatments have you received for this problem?

☐ X-ray ☐ CT scan ☐ MRI ☐ Bone scan ☐ CT scan ☐ Blood tests ☐ Nerve tests (EMG)
☐ Myelogram ☐ Nerve injection (nerve root block) ☐ Joint injection ☐ Discogram (X-ray of discs in back)
☐ Other ____

List **ALL surgeries** you have had and the approximate date. (Example: hip replacement, 1999)

____

____

List **ALL allergies** and any reactions: ____________________________________

____

List **ALL current medications** you are taking. Include dosage AND time you take them.

Medicine (or herb)	Dosage	Frequency
(Example: Motrin)	**800mg**	**One pill at 8:00 am and one pill at 4:00 pm)**

What active medical conditions do you have (check all that apply)

☐ Diabetes ☐ Rheumatoid arthritis ☐ COPD ☐ Sleep apnea
☐ AFIB ☐ Reflux ☐ Hypertension ☐ Anemia ☐ Other ____________________

List any serious past medical conditions you may have had ____________________________

____

List any substance use:	**Currently use**	**Previously used**	**How much**	**How long**	**Stopped**
Tobacco	☐ yes ☐ no	☐ yes ☐ no	______	______	______
Caffeine (coffee, tea, soda)	☐ yes ☐ no	☐ yes ☐ no	______	______	______
Beer, wine, liquor	☐ yes ☐ no	☐ yes ☐ no	______	______	______
Recreation / street drugs	☐ yes ☐ no	☐ yes ☐ no	______	______	______

Family medical history:

Relative	**Currently age**	**(or age at death)**	**Current medical conditions (or cause of death)**
Father	______	______	____________________
Mother	______	______	____________________
Brothers/Sister	______	______	____________________
Children	______	______	____________________

List hobbies: ____

List any exercise: ____

Check any of these NEW problems that may apply to you:

☐ Weakness/arms ☐ Weakness/legs ☐ Difficulty w/ balance ☐ Fevers ☐ Chills ☐ Sweats ☐ Loss of appetite
☐ Unexpected wt. loss (more than 10 lbs) ☐ History of cancer ☐ Bladder problems ☐ History of steroid use
☐ Constipation ☐ Bowel problems ☐ Pain wakes me up ☐ Fevers ☐ Other: ____________________

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Review of symptoms:

General: ☐weight change ☐other: ____________________

Skin: ☐rashes ☐lumps ☐sores ☐change in color/size of mole ☐other: ____________________

Head: ☐headaches ☐head injury☐other____________________

Eyes: ☐sudden loss of vision ☐double vision ☐cataracts ☐glaucoma ☐eye pain ☐eye redness
☐**other:** ____________________

Ears: ☐sudden loss of hearing cringing ☐vertigo cinfection cdrainage

Nose and sinus: ☐nosebleeds ☐sinus ☐other ____________________

Mouth and throat: ☐dentures ☐decayed teeth ☐bleeding gums ☐sores in mouth ☐hoarseness
☐difficulty swallowing ☐other ____________________

Neck: ☐lumps in neck ☐swollen glands ☐goiter ☐pain or stiff neck ☐other

Breasts: ☐lumps ☐nipple discharge ☐dimpled skin ☐other____________________

Respiratory: ☐**r**ecurrent cough ☐excessive sputum ☐wheezing ☐asthma☐emphysema
☐**pneumonia** ☐tuberculosis ☐positive skin test for TB ☐shortness of breath ☐**s**leep apnea
☐other ____________________

Cardiac: ☐high or low blood pressure ☐rheumatic fever ☐heart attack ☐chest pain at rest or on exertion
☐irregular heart rate ☐swelling of both legs or ankles ☐sleep on two or more pillows ☐high cholesterol
☐other ____________________

Blood vessels in legs: ☐leg cramps when walking ☐varicose veins ☐cold feet ☐sores on feet or ankles
☐blood clots in legs ☐other

Gastrointestinal: ☐heartburn ☐recurrent nausea or vomiting ☐recurrent constipation or diarrhea
☐rectal bleeding ☐black stool ☐loss of bowel control ☐ulcer ☐hernias ☐abdominal pain ☐jaundice
☐liver or gall bladder problems ☐hepatitis ☐colon polyp/tumor ☐other

Urinary: ☐frequent urination ☐burning on urination ☐recurrent bladder or kidney infections ☐loss of bladder control ☐kidney stones ☐decreased force of urinary stream ☐blood in urine
☐other ____________________

Male genital: ☐drainage from or sores on penis ☐pain or lump in testicles ☐prostatitis ☐scrotal swelling
☐difficulty in sexual functioning ☐ history of sexually transmitted disease
☐other ____________________

Female genital: ☐date of last menstruation ____________ ☐age at menopause
☐complications of pregnancy ☐drainage from vagina ☐ sores or lumps in and around vagina ☐abnormal bleeding ☐difficulty in sexual function ☐history of sexually transmitted diseases
☐other ____________________

Nerve problems: ☐black-outs ☐seizure or convulsions ☐paralysis ☐frequent or constant numbness or tingling in a body part ☐abnormal memory loss ☐tremors ☐history of polio or muscular sclerosis or stroke
☐Slurred speech ☐other ____________________

Blood problems: ☐anemia ☐easy bruising or bleeding ☐splenectomy ☐leukemia ☐other

Other glands: ☐over/under active thyroid ☐diabetes ☐excessive urination ☐sweating or thirst ☐enlarged

Lymph nodes: ☐other ____________________

Emotional problems: ☐excessive nervousness ☐worry ☐anxiety ☐depression ☐insomnia

Other: ____________________