Orange Orthopedic Medical Group

REGISTRATION FORM

Today's date:		**PLEASE PRINT**

PATIENT INFORMATION

Patient's last name:	First Name:	Middle:	Birth Date:	Marital status (circle one)
			/ /	Single / Married / Divorced/ Separated / Widow

Street address:	Social Security number:	Sex:
		❑ M ❑ F

City:	State:	Zip Code:	Driver's License number:

Home Phone number:	Cell phone number:	Email address:
( )	( )	@

Occupation:	Employer:	Employer phone:

Pharmacy:	Address:	Phone:
		( )

SPOUSE (HUSBAND OR WIFE) OR, IF PATIENT IS A CHILD, OTHER PARENT

Last name:	First Name:	Middle:	Birth Date:	Phone number:
			/ /	( )

Street address:	Social Security no.:	Sex:
		❑ M ❑ F

City:	State:	Zip Code:	Relationship to patient:

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Phone number:
	/ /		( )

Primary insurance:	

Subscriber's name:	Subscriber's Social Security number:	Birth date:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary insurance:	

Subscriber's name:	Subscriber's Social Security number:	Birth date:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	Relationship to patient:	Phone no.:
		( )

Address:	City	State	Zip

PRIMARY CARE PHYSICIAN

Name/Address/Phone	

I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Orange Orthopedic Medical Group, Inc.

_____

Signature

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Date of Birth: _____ Height: _____ Weight: _____

Primary Physician: _____ Right-handed ❑ Left-handed ❑

Past medical history

Please list medical problems/diseases that you have had in the past, or are currently being treated for, and who treated them (including heart disease, lung, stomach, intestines, kidney, liver, arthritis, diabetes, cancer, high blood pressure).

MEDICAL PROBLEM	YEAR	TREATING DOCTOR

PAST SURGICAL HISTORY

Please list ALL surgeries, the year, and the surgeon

SURGERY	YEAR	SURGEON

MEDICATIONS

Please list all medications, doses, and frequency.

MEDICATION	DOSE	FREQUENCY

ALLERGIES

Please list all allergies and reactions.

ALLERGY	TYPE OF REACTION

ORTHOPEDIC INJURIES

Please list previous fractures, sprains, or other significant injuries to your neck, back, legs, or arms.

INJURY	YEAR

FAMILY HISTORY

Please list immediate family, their medical problems, and/or cause of death.

Family Member	Age	Health Status or Cause of Death
Mother		
Father		
Sibling		
Sibling		
Child		
Child		

Social History

Occupation: _____

Alcohol intake: Never ❑ Rarely ❑ Moderately ❑ Daily❑

Cigarette Use: Never ❑ Currently Smoke ❑ # of packs/a day_____ for how many years _____?

Previously Smoked ❑ # of packs/a day_____ for how many years _____? How many years? _____

Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

Patient Signature _____ **Date** _____

PATIENT NAME: _____ DATE: _____

Our doctors are required to get the information listed below to meet the requirements for the Medicare Access and CHIP Reauthorization Act (MACRA) program, which was implemented by The Centers for Medicare and Medicaid Services (CMS). It is a program instituted to fundamentally change the way the United States Evaluates and pays for healthcare.

PLEASE FILL OUT COMPLETELY:

Do you have an ADVANCED CARE PLAN/ADVANCED DIRECTIVE? (please check one)

- o NO
- o YES

IF YES:

- o Do Not Resuscitate
- o Durable Power of Attorney for Healthcare
- o Living Will
- o No Surrogate Decision Maker
- o Patient refused to discuss advance care planning
- o Surrogate decision maker

TOBACCO USE: (please check one)

STATUS:

- o Current Smoker
- o Former Smoker
- o Never Smoked
- o Uses tobacco in other forms

I*F YES: How often do you smoke cigarettes?*

- o Every day
- o Some days, but not every day

How Many Cigarettes a day do you smoke? (please check one)

- o 5 or less
- o 6-10
- o 11-20
- o 21-30
- o 31-more

How soon after you wake up do you smoke your first cigarette?

- o within 5 minutes
- o 6-30 minutes
- o 31-60 minutes
- o After 60 minutes

ARE YOU INTERESTED IN QUITTING? (please check one)

- o Ready to quit
- o Thinking about quitting
- o Not ready to quit.

If you are a former smoker, how long has it been since you last smoked? (please check one)

- o Less than a month
- o 1-3 months
- o 3-6 months
- o 6-12 months
- o 1-5 years
- o 5-10 years
- o More than 10 years

***For your information, the use of tobacco may delay healing, and cessation is recommended.**

ALCOHOL USE: (please check one)

Did you have a drink containing alcohol in the past year?

- o NO
- o YES

IF YES: HOW OFTEN? (PLEASE CIRCLE ONE)

- o Never
- o Monthly or less
- o 2-4 times a month
- o 2-3 times per week
- o 4 or more times a week

IF YES: How many drinks did you have on a typical day when you were drinking in the past year? (please check one)

- o 1-2
- o 3-4
- o 5-6
- o 7-9
- o 10 or more.

IF YES: How often did you have 6 or more drinks on one occasion in the past year? (please check one)

- o Never
- o Less than monthly
- o Monthly
- o Weekly
- o Daily or almost daily

***For your information, the use of alcohol may raise your blood pressure.**

Current Review of Systems Medical Questionnaire

PATIENT NAME: _____ **DATE:** _____

General

Weight gain	O Yes	O No
Fever	O Yes	O No
Night sweats	O Yes	O No
Unexplained weight loss	O Yes	O No

ENT

Hearing impairment	O Yes	O No
Ringing in ears	O Yes	O No
Scalp Tenderness	O Yes	O No

Nervous System

Headache	O Yes	O No
Weakness, Numbness, Tingling	O Yes	O No
Dizziness	O Yes	O No

Heart/Circulatory

Hypertension	O Yes	O No
Chest pain	O Yes	O No
Palpitations	O Yes	O No
Pacemaker	O Yes	O No
Heart Attack/Heart failure	O Yes	O No

Respiratory

Asthma	O Yes	O No
Lung Disease	O Yes	O No
Breathing difficulty	O Yes	O No

Digestive System

Ulcer Disease	O Yes	O No
Diarrhea	O Yes	O No
Vomiting/nausea	O Yes	O No
Constipation	O Yes	O No
Hepatitis	O Yes	O No
Abdominal pain	O Yes	O No
Reflux	O Yes	O No

Genitourinary

Urinary Tract Infection	O Yes	O No
Urinary Bleeding	O Yes	O No
Altered Menses	O Yes	O No
Uncontrolled Urination	O Yes	O No
Kidney Disease	O Yes	O No

Blood

Bleeding Disorder	O Yes	O No
Swollen Glands	O Yes	O No
Anemia	O Yes	O No
Blood Tumors/Disease	O Yes	O No

Musculoskeletal

Joint stiffness	O Yes	O No
Joint pain	O Yes	O No
Back Pain	O Yes	O No
Prior Bone fracture	O Yes	O No
Other Physical Limitations	O Yes	O No

Psychology

Depression	O Yes	O No
High stress level	O Yes	O No
Mood Swings	O Yes	O No
Panic Attacks	O Yes	O No

Endocrinology

Diabetes	O Yes	O No
Thyroid Disease	O Yes	O No
Hormonal Disease	O Yes	O No

Neurology

Stroke	O Yes	O No
Seizures	O Yes	O No
Gait Difficulties	O Yes	O No

Dermatology

Rash	O Yes	O No
Hives	O Yes	O No
Mass/Tumors	O Yes	O No

Family History

Mother still living	O Yes	O No
Father still living	O Yes	O No
Do you have children	O Yes	O No

- o 1
- o 2
- o 3
- o 4
- o More than 4: _____

Social History

Live alone O Yes O No

- o With spouse
- o With Children
- o With Other _____

Do you work O Yes O No

- o Full Time
- o Part Time

Exercise O Yes O No

- o 1-3x/week
- o 4-7x/week

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ELIGIBILITY GUARANTEE FORM

☐ **PATIENTS WITHOUT INSURANCE**:

I, _____ hereby certify that I **do not** have insurance
(Print name clearly)
coverage, and I agree to pay in full for all services, on the day they are rendered. I am aware that payment can be made by cash, check, or credit card. ***(Sign below)***

☐ **PATIENTS WITH INSURANCE**:

I, _____ hereby certify that I am eligible with the
(Print name clearly)
following health insurance company, _____ under the subscriber (name/self/spouse/parent), _____, through his or her employer, _____. If I have an HMO insurance, I have chosen St. Joseph Hospital Affiliated Physicians as my medical group. I also certify that I have chosen Dr._____ to be my medical provider. I understand that if the above is not true or if I am not eligible under the terms of my Medical and Subscriber Agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill from the above noted physician. I also agree to inform the provider of any changes in my personal information (address, phone number, etc.) or my medical coverage.

_____
Signature of Patient/Member

_____
Verified by

_____
Date

****Billing your insurance company, or workman's compensation carrier is a courtesy that our office is pleased to extend to you. If for any reason we do not receive payment from any outside source, the patient is responsible for the balance in full.**

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab, scan and/or test results to me as soon as possible. However, if I do not hear from my physician's office within 1 week after getting my test, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he feels are best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Open Payments database
"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have.
If you need more information about your health or condition, please ask.

_____

Patient Signature Date Physicians Signature

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PLEASE READ AND SIGN BELOW

Medication Prescription Protocol and Patient Responsibility Form

Due to increased surveillance and requirements from the Drug Enforcement Agency and California Medical Board, Orange Orthopedic Medical Group, Inc. has adopted some professional policy standards for patients, doctors and staff with respect to prescribing and renewing medications.

Narcotic medication will not be dispensed to any patient without approval from one of the above listed Orthopedic Surgeons.

Requests for medication refills will only be honored by pharmacy requests via fax with 72 hours' advance notice.
NO refills will be granted by patient requests.

Medication refills will **not** be available after office hours, weekends or holidays.

Medication refills will **not** be granted by walk-in patients without prior written authorization by one of the above listed Orthopedic Surgeons.

All medication dispensed to the patient is the responsibility of the patients and is to be taken as directed by the prescribing doctor. No refills will be granted for patients who missed their last scheduled appointment, or who have not been seen in the last 6 months.

We do believe that this protocol will not only improve safety issues with medication for patients but will also improve professional and ethical standards in delivering quality medical care.

RX History Consent

I give permission for Orange Orthopedic Medical group, Inc to view my outside medication history

_____

Signature of Patient/Member Print Name

Returned Patient Calls

Due to the doctor's busy clinic and surgery schedules, please allow 2 business days for all returned patient calls/questions left for your doctor. Exceptions will be made for emergency situations.

I _____ understand and agree with the instructions given to me by OOMG, Inc.,
(Print Name)

Patient Signature _____ Date _____

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Voicemail or Email Messages

There may be times when our office is not able to reach you by telephone. With your permission, we would like to be able to leave messages on your voicemail or email you. To comply with strict legal standards, a written release will allow us to leave a message on your voicemail or allow us to email you. By signing below, you are authorizing us to contact you by email or voicemail.

Preferred contact phone number (_____) _____

Preferred email address _____

DESIGNATED PARTY AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Some patients prefer that another individuals, especially family members, be allowed access to their medical information. To comply with strict legal standards, a written release is required to allow another person access to your medical records.

This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication.

1. Designated Party: _____

Telephone: _____ Relationship: _____

2. Designated Party: _____

Telephone: _____ Relationship: _____

HIPAA

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ 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

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Disability & Insurance Claim Form Policy

Disability and insurance claim forms are completed on a first come, first served basis. Each Form is date stamped when they are received. They are then processed in that order.

The normal processing period for these forms is seven to ten (7-10) **working days.** This time frame allows us to obtain the dictation from the doctor for an accurate disability status. State Disability has an online process for submitting disability claims. Please see next page for instructions.

For patients who have a "Return to Work" form and are returning to work the **same** day as their evaluation, we will be able to have the form completed by the end of the day.

Please advise the front desk if you have any form that needs to be completed when you check in for your appointment. If you would like us to mail your form for you, please provide us with an addressed, stamped envelope.

Our office requires patients to pay a fee, **in advance**, for each disability/insurance/work form submitted to us for completion.

Fee Schedule:

Misc Forms	**1-2 Pages**	**$12**
	3-5 Pages	**$20**
	6 pages +	**$25**
State Disability	**Initial Claim**	**$20**
Paper or Online	**Extension**	**$12**

Although our office is more than happy to fill out your disability/insurance/work forms, it is ultimately the patient's responsibility to know and understand your employer's disability requirements and policy.

I have read and understand the policy above.

_____ _____

Patient's Signature **Date**

_____

Print Patient's Name

*****As a courtesy we have included instructions for submitting State Disability claims online on the next page.

SDI Online Tips

Employment Development Department
State of California

Are you unable to work because of a pregnancy, non-work-related disability or need to bond with a new child, care for an ill family member, or assist a military family member? Use SDI Online to apply for Disability Insurance (DI) or Paid Family Leave (PFL) benefits!

Get Started Today!

Create Your myEDD Account

If you already have a myEDD account, you may skip this step.

- Visit myEDD (myedd.edd.ca.gov) and select **Create Account**.
- Enter a personal email and create a password.
- Select your preferred language and accept our terms and conditions.
- Check your email. Select the unique link within 48 hours to complete the process or you'll need to start over.

Make sure to check your spam folder if you don't see this message in your inbox.

Register in SDI Online

Log in to myEDD and select **SDI Online** to begin registration.

- Select the **Register as a Claimant** link.
- Enter all required information such as legal name and date of birth as it appears on your California Driver's license (CDL) or identification (ID) card.
- Select **Submit** and save your EDD Customer Account Number for future reference.

You will need to file by mail if you do not have a CDL or ID.

File Your DI or PFL Claim

Log in to myEDD and select **SDI Online** to get started.

- Select **New Claim**.
- Select the appropriate link to apply for DI or PFL benefits.
- Enter all required information including your employer's details, last date worked, wages received after you stopped working, and any workers' compensation information, if applicable.
- Review the information you entered and select **Submit**.
- After submitting your claim, a confirmation page will display. Save your receipt number and follow the instructions to complete your DI or PFL claim.

What's Next?

DI claims require a medical certification for your disability. Provide your receipt number to your licensed health professional (edd.ca.gov/en/Disability/Physicians-Practitioners).

Care claims require a completed Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC) uploaded to the claim. The licensed health professional can complete their certification through SDI Online or by using the DE 2501FC.

Bonding claims require proof of relationship documentation:

- Child's birth certificate.
- Foster care placement record.
- Adoptive Placement Agreement.
- New mothers transitioning from a DI pregnancy claim do not need to submit proof of relationship documentation.

Military Assist claims require supporting military documentation:

- Covered active duty orders.
- Letter of impending call or order to covered duty.
- Documentation of leave for Rest and Recuperation.
- Documentation of the qualifying events.

After you upload all necessary documents, we will review your claim and notify you of approval or denial within 14 days.

For additional help with your SDI Online account, view the SDI Online Tutorials (edd.ca.gov/en/disability/SDI_Online_Tutorials/).

DE 8515 Rev. 6 (6-23) (INTERNET)