Orange Orthopedic Medical Group

REGISTRATION FORM

Today's date:		**PLEASE PRINT**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth Date:	Marital status (circle one)
			/ /	Single / Mar / Div. / Sep / Wid

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

City:	State:	Zip Code:	Driver's License No.

Home Phone no:	Cell phone no:	Email address:
( )	( )	@

Occupation:	Employer:	Employer phone:

Pharmacy:	Address:	Phone:
		( )

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

Last name:	First:	Middle:	Birth Date:	Phone no.:
			/ /	( )

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 no.:
	/ /		( )

Primary insurance:	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:

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

Secondary insurance:	

Subscriber's name:	Subscriber's S.S. no.:	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/Add/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, dose, 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 in order 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? ___NO ___YES

IF YES: ___Do Not Resuscitate ___Living Will ___Organ Donor ___Power of Attorney

TOBACCO USE:
STATUS: ___ Current Smoker ____ Former Smoker ____ Never Smoked ____ Light Tobacco Smoker ____Heavy Tobacco Smoker ____Uses tobacco in other forms

IF YES: HOW OFTEN DO YOU SMOKE CIGARETTES?
___Every day ___Some days, but not every day

IF YES: HOW MANY CIGARETTES A DAY DO YOU SMOKE?
____5 or less ____6-10 ____11-20 ____21-30 ____31-more

IF YES: HOW SOON AFTER YOU WAKE UP DO YOU SMOKE YOUR FIRST CIGARETTE?
___within 5 min ___6-30 min ___31-60 min ___after 60 min

IF YES: ARE YOU INTERESTED IN QUITTING?
___Ready to quit ____Thinking about quitting ___Not ready to quit

IF FORMER SMOKER: HOW LONG HAS IT BEEN SINCE YOU LAST SMOKED?
___< month ____1-3 months ___3-6 months ___6-12 months ___1-5 years ___5-10 years ___> 10 yrs

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

ALCOHOL USE:
DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR? ___YES ____NO

IF YES: HOW OFTEN?
___Never ____Monthly or less ____2-4 times a month ___2-3 time per week ___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? ___1-2 ___3-4 ___5-6 ___7-9 ___10 or more

IF YES: HOW OFTEN DID YOU HAVE 6 OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR?
___Never ___less then monthly ____monthly ____weekly ____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**:_____

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

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

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

Neurology

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

Dermatology

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

Endocrinology

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

Respiratory

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

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

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

Family History

Mother still living O Yes O No
Father still living O Yes O No
Do you have children O No O 1 O 2
O 3 O 4 O More:___

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/wk O 4-7x/wk

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Reilly Carr, PA-C

1310 W Stewart Drivee, Suite 408
Orange, CA 92868
(714)538-8549 Fax (714)538-1547

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.

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, doctor's 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 confirm to 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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ANSWERING MACHINE 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 home answering machine. In order to comply with strict legal standards, a written release will allow us to leave a message on your answering machine. By signing below, you are authorizing us to leave messages on your answering machine at the telephone number you have given us in your record.

Preferred contact phone number (_____) _____Circle One: Home / Work / Cell

DESIGNATED PARTY AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order 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