

**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:
					<input type="checkbox"/> M <input type="checkbox"/> 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:
					<input type="checkbox"/> M <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Secondary insurance:					
Subscriber's name:			Subscriber's S.S. no.:		Birth date:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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

Orange Orthopedic Medical Group, Inc.

General History Form

DATE: _____

NAME: _____

OCCUPATION: _____

Present Complaint: Why are you here today? _____

History of Present Illness/Injury: _____

How and where did the Injury occur? _____

When did the injury occur (specific date if possible)? _____

Has it gotten worse recently? _____

What makes It better? _____

What makes it worse? _____

Please indicate former major illnesses: _____

Orange Orthopedic Medical Group, Inc.

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1310 W. Stewart Drive, 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.**

Current Review of Systems Medical Questionnaire

Patient Name: _____ Date: _____

Psychology

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

Musculoskeletal

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

General

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

ENT

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

Nervous System

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

Neurology

Stroke Yes No
Seizures Yes No
Gait Difficulties Yes No

Digestive System

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

Dermatology

Rash Yes No
Hives Yes No
Mass/Tumors Yes No

Endocrinology

Diabetes Yes No
Thyroid Disease Yes No
Hormonal Disease Yes No

Respiratory

Asthma Yes No
Lung Disease Yes No
Breathing difficulty Yes No

Genitourinary

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

Heart/Circulatory

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

Blood

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

Family History

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

Social History

Live alone Yes No With spouse
 With Children With Other

Do you work Yes No
 Full Time Part Time

Exercise Yes No
 1-3x/wk 4-7x/wk

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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 doctors 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

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 Smoker ___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 than monthly ___monthly ___weekly ___daily or almost daily

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