Patient Information

PATIENT INFORMATION

Date _____

SSN/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

_____
City State Zip Code

Cell (____) _____

Best time/place to contact you? _____

E-mail _____

Sex ☐ M ☐ F Age _____

Date of Birth _____

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Minor

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____
City State Zip Code

Employer/School Phone (____) _____

Spouse's Name _____

DOB _____ SSN _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Y ☐ N

Subscriber's Name _____

Date of Birth _____

Social Security # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Memorial Orthopaedic Surgical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed on page 8 of these forms.

TO BE COMPLETED BY PARENT/GUARDIAN

Name _____

Relationship _____ SSN _____

Address _____

_____

Cell (____) _____

Home (____) _____

Work (____) _____

E-mail _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of Accident

☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your incident?

☐ Auto Ins ☐ Employer ☐ Worker's Comp ☐ Other

Attorney's Name (if applicable) _____

Name:_____ MRN _____

Patient Information

EMERGENCY CONTACT

Name _____ Relationship _____

Home ( ) _____ Cell ( ) _____ Work ( ) _____

In order to effectively communicate with you about your medical information, we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information, or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voicemail.**

Please check all boxes that you give Memorial Orthopaedic Surgical Group permission to use for your communications:

☐ You may contact me by telephone.	Phone Number ( ) _____
☐ You may leave a message/voicemail.	Phone Number ( ) _____
☐ You may contact me by mail.	
☐ You may contact me through email (Mychart).	

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Personal Health History

A. Have you ever had or do you take medications for:	(please circle)	**If yes, please detail:**
1. Heart Disease or Heart Attack	Yes/No	
2. Seizures/Stroke	Yes/No	
3. Lung Disease (e.g. pneumonia, asthma, emphysema, T.B.)	Yes/No	
4. Stomach or Bowel Problems	Yes/No	
5. Circulation Problems	Yes/No	
6. Diabetes	Yes/No	
7. High Blood Pressure	Yes/No	
8. Cancer	Yes/No	
9. Thyroid Problems	Yes/No	
10. HIV/AIDS	Yes/No	
11. Hepatitis or Jaundice	Yes/No	
12. Bleeding/Blood Problems (e.g. hemophilia, anemia, sickle cell disease)	Yes/No	
13. Allergy to Medication (if yes, what reaction? Rash, swelling, etc.)	Yes/No	
14. Allergy/Sensitivity to Latex, Metal, Iodine, Shellfish	Yes/No	
15. DVT/PE (blood clot in legs or lungs) in you or family member	Yes/No	
16. Other Medical Issues	Yes/No	
17. Broken Bones (if yes, which ones and when?)	Yes/No	
18. Head Injuries (if yes, when?)	Yes/No	
19. Neck Injuries (if yes, when?)	Yes/No	
20. Back Injuries (if yes, when?)	Yes/No	
21. Seriously ill or hospitalized? If so, with what illness/problem?	Yes/No	
22. Are you pregnant?	Yes/No	

B. Current Medications: _____

_____

C. Are you presently under the care of any other doctor? If yes, for treatment of what condition?

_____

D. Past Surgeries: _____ **F. Body Part Evaluated Today:** _____

F. Date of Injury or Onset of Pain: _____

- How did it start? _____
- Describe Symptoms: _____

G. Occupation: _____

Height _____ Alcohol _____ How much? _____ Left / Right Handed **(please circle)**

Weight _____ Smoke _____ How much? _____ Former smoker? _____

Name: _____ Date: _____

Family Health History

A. Has anyone in your family ever had? (please circle)

1. Alcohol/Drug	Yes/No	Father/Mother/Sister/Brother
2. Allergies	Yes/No	Father/Mother/Sister/Brother
3. Anesthesia Problems	Yes/No	Father/Mother/Sister/Brother
4. Arthritis	Yes/No	Father/Mother/Sister/Brother
5. Blood Disorder	Yes/No	Father/Mother/Sister/Brother
6. Cancer	Yes/No	Father/Mother/Sister/Brother
7. Diabetes	Yes/No	Father/Mother/Sister/Brother
8. Dementia	Yes/No	Father/Mother/Sister/Brother
9. Genetic/ Inherited	Yes/No	Father/Mother/Sister/Brother
10. GI	Yes/No	Father/Mother/Sister/Brother
11. Genitourinary (GU)	Yes/No	Father/Mother/Sister/Brother
12. Heart Condition	Yes/No	Father/Mother/Sister/Brother
13. Hemophilia	Yes/No	Father/Mother/Sister/Brother
14. Hypertension	Yes/No	Father/Mother/Sister/Brother
15. Lipids	Yes/No	Father/Mother/Sister/Brother
16. Psychiatry	Yes/No	Father/Mother/Sister/Brother
17. Pulmonary	Yes/No	Father/Mother/Sister/Brother
18. Sickle Cell	Yes/No	Father/Mother/Sister/Brother
19. Stroke	Yes/No	Father/Mother/Sister/Brother
20. TB	Yes/No	Father/Mother/Sister/Brother
21. Thyroid	Yes/No	Father/Mother/Sister/Brother

NOTICE OF MEDICAL PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, or health care operations.

- **Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.**

- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**

- **Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.**

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

NOTICE OF MEDICAL PRIVACY PRACTICES

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2014 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information at: **<u>Memorial Orthopaedic Surgical Group</u>** **2760 Atlantic Avenue** **Long Beach, CA 90806** **Office #: (562) 424-6666 x259**	**For more information about HIPAA or to file a complaint:** **The U.S. Department of Health & Human Services** **Office of Civil Rights** **200 Independence Avenue, S.W.** **Washington, DC 20201** **202.619.0257** **Toll Free: 1.877.696.6775**

Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request, your organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at **2760 Atlantic Avenue, Long Beach, CA 90806** to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are required to agree to my request, and by agreeing to such request, you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

_____ _____

PATIENT NAME DATE

_____ _____

SIGNATURE RELATIONSHIP TO PATIENT

Financial Interest Consent

I, _____ (patient), acknowledge and accept that my physician may have a financial interest in Hospital, Surgery Centers, Imaging Centers, and Physical Therapy and/or Surgical Devices that he/she chooses to utilize. I hereby recognize my right to choose another Physician or request the services of another facility or device to be used.

Patient Assent

BY MY SIGNATURE, OR BY THAT OF A PARENT OR OTHER RESPONSIBLE PARTY, I HEREBY ACKNOWLEDGE THAT I HAVE:

☐ COMPLETED THE "PATIENT INFORMATION" SHEET (PAGES 1 AND 2)
☐ COMPLETED THE "PERSONAL AND FAMILY HEALTH HISTORY" (PAGES 3 AND 4)
☐ READ THE "NOTICE OF MEDICAL PRIVACY PRACTICES" (PAGES 5 AND 6)
☐ READ THE “PATIENT CONSENT FORM” (PAGE 7)
☐ READ THE "FINANCIAL INTEREST CONSENT" (PAGE 8)

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____
PRINT NAME RELATIONSHIP TO PATIENT