Non-Surgical Orthopedic Center

Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age: _____ SS#_____

Address: _____ Apartment#_____

City: _____ State: _____ Zip: _____

Which is the **best** way to contact you (Please circle)? Home Telephone Mobile Work Email

Home Telephone: _____ Mobile: _____ Work: _____

E-mail Address: _____

Emergency Contact: _____Relation_____Telephone:_____

Family Physician: _____Telephone_____

Insurance Carrier: _____ Telephone_____

Insurance Subscriber Name: _____ Subscriber DOB:_____

Policy#_____ Group#_____

Secondary Insurance: _____ Telephone_____

Secondary Insurance Subscriber Name: _____ Subscriber DOB_____

Policy # _____ Group#_____

How Did You Hear About Us? _____

Would you like us to send a copy of today's visit to your Primary Doctor? ☐ **Yes** ☐ **No**

What are the main reasons you are seeking care?

_____

_____

_____

_____

How would you describe the pain? (Circle all that apply)

Sharp Dull Burning Shooting Deep Throbbing

How severe is the pain? (1-10) _____

When did your symptoms start? _____

How did your symptoms begin? _____

Are your symptoms getting: Worse or Better

Have you ever experienced these symptoms before? Yes or No

What makes your symptoms worse?

_____

What makes your symptoms better?

_____

Is this condition related to? (Circle)

Auto Accident Work Illness Injury

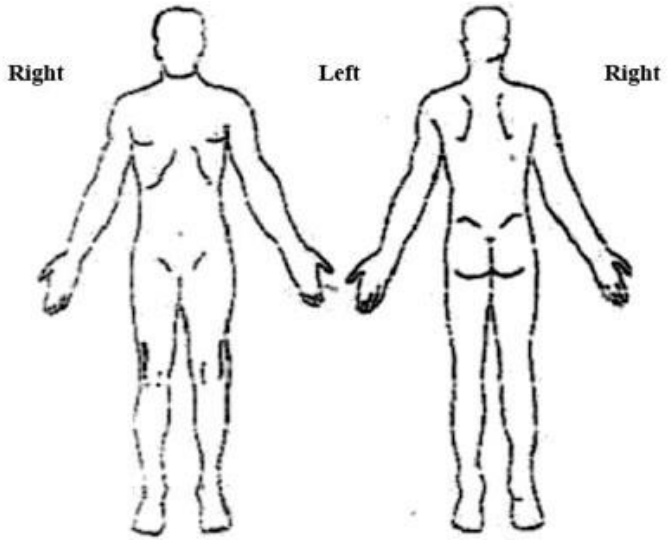
Have you sought out treatment or medication for this complaint before? Yes or No

If yes, please list: _____

Are there any specific treatments you would like to discuss today?

_____

Please Mark all problems areas in which you are seeking treatment:



Medical History:

Please list any medical conditions that you are currently being treated for: (example: High Blood Pressure)

_____

_____

_____

Please list any allergies you have:

_____

_____

Please list any surgeries you have had with approximate date:

_____

_____

Do you drink alcohol? If so, how often and how much? _____

Do you smoke? If so, how often and how much? _____

Family Medical History:

Please list all medical conditions that run in your family: (High Blood Pressure, Cancer, Diabetes etc)

_____

_____

_____

Please tell about other symptoms you may be experiencing: (Circle all that apply)

Skin/Lymphatic: Rash/ New spots/ Skin infections/ Change in a mole/ Non-healing sores/ Swollen lymph nodes

Neurologic: Severe headaches/ Fainting spells/ Seizures and convulsions/ Dizziness, Memory loss

Eyes: Vision problems/ Glaucoma

E.N.T: Hoarseness/ Nose bleeds/ Hearing loss/ Ringing in ears/ Difficulty swallowing/ Tooth pain or infection

Endocrine: Diabetes/ Thyroid disease

Urologic: Burning with urination/ Blood in urine/ Frequency of urination

Allergies/Immune Disease: Hay fever/ Anaphylactic reaction/ Rheumatoid disease/ other autoimmune disease

Gastrointestinal: Heartburn/ Abdominal pain/ Nausea/ Jaundice/ Bloody stool/ Black stool

Musculoskeletal: Joint pain/ Joint swelling/ Back pain/ Neck pain/ Muscle pain

Hematologic: Easy bruising/ Excessive bleeding

Constitutional: Chronic fatigue/ Weight loss/ Excessive weight gain/ Fever/ Night sweats

Cardiovascular: Chest pain/ Racing heart beat/ Poor circulation

Psychological: Depression/ Anxiety

Respiratory: Asthma/ Wheezing/ Shortness of breath/ Persistent cough/ Cough up blood

Medication and Supplement List

Date	Medication/Dose	Directions	Date Stopped	Reason for taking/Doctor

Cancellation Policy

Attn: All Patients

If you must cancel or reschedule your appointment, please do so at least 48 hours in advance. Since we have patients on a waiting list, we can give your appointment to another patient. Please be advised that if you are unable to cancel your appointment at least 48 hours in advance, we must charge you a cancellation fee of $100.00.

If you are unable to reach us by telephone, you may email us: nonsurgicalorthopediccenter@gmail.com

Your signature acknowledges that you have read, understand and agree to this policy.

Thank You for your understanding.

Patient Name: _____

Patient Signature: _____

Date: _____

Financial Responsibility Agreement

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care in our office (if you are accepted as a patient) and you may choose the plan which best fit your needs. Please read carefully and choose the plan you prefer. This information will enable us to better serve you and help avoid misunderstanding in the future. If special arrangements are necessary please consult with the Doctor. Our main concern is your health and well-being, and we will do our best to help you!

CASH- Fees are to be paid at the time services are rendered (every visit), unless special arrangements have been made in advance. Cash, Check, American Express, Visa, Mastercard or Discover.

INSURANCE- If your health insurance plan covers your care; we can bill your insurance directly. Most patients are required to pay a co pay/co-insurance in addition to their yearly deductible. In the event that a payment should come to you, you are expected to bring the check to us endorsed along with the EOB's. The contracted insurance plan is yours, not ours; therefore you are always responsible for your account with us. If you become inactive by discontinuing your care, your account balance is due immediately.

AUTO/ PERSONAL INJURY- You need to supply us with the accident report, your auto insurance, health insurance, liable parties insurance, and attorney information if applicable. Until necessary information is gathered and verified or you have retained an attorney, you will be required to pay for your care. If we can accept your case we will bill your insurance directly. In the event that payment comes to you from the insurance company or your attorney achieves a settlement then we expect payment immediately. If you are released from care or non-compliant with the medical recommendations, the account balance is due within 90 days. You are responsible for payment of all services on your account. If payment on your account is not made the balance will be given to a collection agency.

I UNDERSTAND & ACKNOWLEDGE BEING INFORMED OF THESE OFFICE POLICIES

SIGNATURE_____DATE_____

Disclosure and Consent of Treatment Form for Physical Medicine Modalities

Dear Patient: You have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not you will undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I voluntarily request Dr. Bryan Hawkins D.O, Dr. Roselle Liganor D.O, Dr. Wayne Dillard D.O and/or Dr. Timothy Taylor D.O as my physician, and such associates, technical or medical assistants and other health care providers as they deem necessary, to treat my condition which has been explained to me.

I understand that the following Physical Medicine Modalities are planned for me and I voluntarily consent and authorize these procedures:

Osteopathic Manipulation Treatment Therapeutic Injections . Therapeutic Exercise

Neuromuscular Re-education Acupuncture Electric Stimulation

Manual Therapy Therapeutic Activities

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as a result or cure. I fully understand that the following risks and hazards may occur in connection with these particular procedure:

Increased musculoskeletal pain . Muscle Stiffness . Headaches . Increased menstrual bleeding

Itching . Skin burns/Blistering

I further state that I do not have a **Cardiac Pacemaker**, have not been diagnosed with **Cancer** or in danger of a **Hemorrhage**.

I certify this has been fully explained to me, that I have read or have had it read to me, and that I understand the content.

Patient Signature: _____ Date:_____ Time:_____

Physician or Provider Signature: _____ Date:_____

Non-Surgical Orthopedic Center

2170 S. El Camino Real Ste. 117-122
Oceanside, CA 92054
(760) 730-8060
Fax: (760) 730-8061

Authorization for Release of Medical Records

To: (Provider Name) _____

Provider Address _____

I, (Patient) _____DOB:_____ request the following information:

- ☐ Imaging and Reports
- ☐ All Medical Records
- ☐ Procedure Notes
- ☐ Other: _____

To be released to: Non-Surgical Orthopedic Center

Requested by: Dr. Bryan Hawkins, D.O. ☐

Dr. Roselle Liganor, D.O. ☐

Dr. Wayne Dillard, D.O. ☐

Dr. Timothy Taylor, D.O. ☐

Signature: _____ Date: _____

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

According to Section 25252 of the California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.