Dr. Ahmed S. Bata
Orthopedic Surgeon
Nile Orthopedic and Rehabilitation Association, Inc
25805 Barton Rd, STE A106, Loma Linda CA 92354
Office: (909) 233-7823 Fax: (909) 295-6075 Email: ahmedbata@ahmedbata.com

# New Patient Questionnaire

## PERSONAL INFORMATION

Name: _____ Sex: ☐ M ☐ F DOB: _____ Age_____
Address: _____
City, State, Zip _____
Phone Numbers: home _____work _____other_____
Insurance: company_____ ID#_____ ph#_____
Email: _____ Pharmacy: _____

## ORTHOPAEDIC PROBLEM HISTORY

(You may check more than one answer for the same question)

Purpose of visit (what hurts)? ☐ Ankle ☐ Foot ☐ Heel ☐ Other?
_____
_____

which side? ☐ Left ☐ Right ☐ Both

How did the problem start? ☐ Injury ☐ Deformity ☐ Other?
_____
_____

**Current problem:**
Time of onset: _____
Type of onset: ☐ Sudden Onset ☐ Gradual onset
Frequency of pain: ☐ Constant ☐ Every _____(mins/hour/day/week/month/year)
Duration of pain: _____ (mins/hour/day/week/month/year)
Change over time: ☐ getting better ☐ getting worse ☐ fluctuates ☐ plateaued
_____
_____

**Rate your pain**: (from 0-10 if 0 in no pain and 10 is the worst pain imaginable)
_____
_____

**Precipitating event:** (Like: sport injury, falling, long walk… etc)
_____
_____

**Associated symptoms**: (Like: swelling, numbness, bruising… etc)
_____
_____

Physician Recommendation:

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**What makes symptoms better?**

_____

_____

**What makes symptoms worse?**

_____

_____

**Have you been treated for this problem?** ☐ Yes ☐ No If yes, when and where?

_____

Physician Name_____ Address_____

**What treatment have you had?**

☐ cast/splint ☐ Brace_____ ☐ Injection ☐ Physical Therapy
☐ Orthopedic shoes ☐ Orthotics
☐ Surgery_____
☐ X-ray ☐ CT Scan
☐ MRI ( )Within 6 months ( )More than 6 months

☐ Medicine/Pain medicine _____

☐ Antibiotics_____

Other (please Explain):

_____

_____

_____

**Did you go to the hospital, ER or urgent care for this current problem?**

_____

_____

_____

**Is there anything else you would like us to know? Please write below, or proceed to next page.**

_____

_____

_____

_____

_____

_____

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## MEDICAL HISTORY

**Do you have, or have you ever had any of the following?** (Please describe)

| **Diagnosis** | | **Describe** | **Date** |
|---|---|---|---|
| Diabetes | ☐Yes ☐No | | |
| Hepatitis | ☐Yes ☐No | | |
| High Cholesterol | ☐Yes ☐No | | |
| HIV | ☐Yes ☐No | | |
| Hypertension | ☐Yes ☐No | | |
| Stroke | ☐Yes ☐No | | |
| Cancer | ☐Yes ☐No | | |
| Head, Eyes, Ear, Nose & Throat | | ☐Yes ☐No | |
| Lung Disease | ☐Yes ☐No | | |
| Heart Disease | ☐Yes ☐No | | |
| Stomach/GIT Disease | ☐Yes ☐No | | |
| Liver disease | ☐Yes ☐No | | |
| Kidney disease | ☐Yes ☐No | | |
| Urinary Problems | ☐Yes ☐No | | |
| Obstetric/Gynecology | ☐Yes ☐No | | |
| Musculoskeletal | ☐Yes ☐No | | |
| Neurology Problems | ☐Yes ☐No | | |
| Blood/ Lymphatic | ☐Yes ☐No | | |
| Thyroid disease | ☐Yes ☐No | | |
| Other Endocrine | ☐Yes ☐No | | |
| Infectious disease | ☐Yes ☐No | | |
| Rheumatology | ☐Yes ☐No | | |
| Other Problems | ☐Yes ☐No | | |

**Do you have a family history of any of the above problems? (**Please describe)

**Have you ever had surgery?**

| Procedure | Date | Hospitalized? (Days) | Complications?(what) |
|---|---|---|---|
| | | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Yes ☐No | ☐Yes ☐No |

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## REVIEW OF SYSTEMS

➢ Have you recently had any of the following problems? Please check ✓ all boxes below that apply to you.

| Problem | | Yes | No | If yes, please explain |
|---|---|---|---|---|
| 1. **Constitutional** (overall) | a. Weight gain | | | |
| | b. Weight loss | | | |
| | c. Fever | | | |
| | d. Chills | | | |
| | e. Night sweats | | | |
| 2. **Eyes** | a. Vision change | | | |
| 3. **Head, Ears, Nose, Throat** | a. Difficulty hearing | | | |
| | b. Hoarseness | | | |
| 4. **Breast** | a. Breast Masses | | | |
| 5. **Cardiovascular** (heart) | a. Chest pain | | | |
| | b. Irregular heartbeat | | | |
| 6. **Respiratory** (breathing) | a. Shortness of breath | | | |
| 7. **Gastrointestinal** (digestion) | a. Stomach ulcers | | | |
| | b. Heartburn | | | |
| | c. Jaundice | | | |
| 8. **Genitourinary** (urination) | a. Frequent urination | | | |
| | b. Painful urination | | | |
| 9. **Skin/ Integument** | a. Rash | | | |
| | b. Skin problems | | | |
| 10. **Neurological** (nervous system) | a. Headaches | | | |
| | b. Numbness | | | |
| 11. **Musculoskeletal** (muscles & bones) | a. Joint pain | | | |
| | b. Night pain | | | |
| 12. **Endocrine** (hormones and glands) | a. Fatigue | | | |
| 13. **Psychiatric** (emotions) | a. Depression | | | |
| 13. **Hematologic** (blood) | a. Anemia | | | |
| | b. Bleeding disorders | | | |
| | c. Blood transfusion | | | |

Please Select form the above table **ONLY** recent untreated conditions

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**What Medication do you take?**

| Medication | dose | frequency | Medication | dose | frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Do you have Allergies?**

| Substance/ Medication | reaction | Substance/Medication | reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Females: Are you pregnant?** ☐Yes ☐No (Please let us know if there is any probability you may be pregnant. Xrays may harm your baby)

**SOCIAL HISTORY**

Do you Smoke? ☐Yes ☐No Packs/day? _____ Years _____ Quit (yrs) _____
Do you drink alcohol? ☐Yes ☐No ☐ daily ☐ weekly ☐ monthly ☐ Socially

History of substance abuse? ☐Yes ☐No what? _____
Frequency _____ ☐ daily ☐ weekly ☐ monthly ☐ Socially

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐widowed
Do you live alone? ☐Yes ☐No

Occupation: _____
Employment Status: ☐employed ☐unemployed ☐retired ☐disabled

**Signature of Patient/ Legal Guardian:** **Date:**

_____ _____

If Legal Guardian,
Name: _____ Relation: _____

**Signature of Dr. A Bata:** _____

By signing above, I (Dr. Bata) acknowledge that I have reviewed this form and discussed the relevant medical concerns with the patient. This form is part of the patient's medical records.

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# Protected Health Information (PHI) / HIPAA

**Patient Name (Print) :**_____ **Date** :_____

Due to recent implemented Federal Regulations the following public notice by Nile Orthopedic and Rehabilitation Association, Inc. is effective as of November 1, 2011.

**Nile Orthopedic and Rehabilitation Association, Inc is required to:**

1. Maintain the privacy of your health information.
2. Provide you with this notice as to what our legal duties and privacy practices are with respect to information we collect and maintain about you.
3. Abide by the terms of this practice.
4. Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
5. We will not use or disclose your health information without your authorization, except as described in this notice.
6. We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

**WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUSTANCES:**

1. **Disclose Required By La**w: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.
7. Your PHI will be shared and available to our office personal depending on their duties.
8. We may share your PHI with your other providers and healthcare facilities as needed to facilitate your care. We may share your PHI with third party companies as needed for our office operation, this may include but not limited to billing, insurance and electronic health records companies.

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Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice might routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions.

All requests for medical records should be hand written and should contain:

**Full Name** **Date of Birth**
**Mailing Address** **Phone Number**
**Written Signature**

**An additional fee might be asked for generating a copy or mailing all medical records as per the rules practiced by the clinic.**
At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

**Patient Rights**

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions**: You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to request and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances. However, you may request a review of our denial.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. Your request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**If you have any questions regarding this notice or would like to exercise any of your rights under this notice, you may contact:**

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**Loma Linda, Ca 92354**
**Phone 909-233-7823**

# Nile Orthopedic and Rehabilitation Association, Inc.

****Complete and return to Receptionist****

## ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Nile Orthopedic and Rehabilitation Association, Inc. and understand that if I have questions regarding this Notice I may contact the office at 25805 Barton Road Suite A106 Loma Linda, CA 92354, Phone 909-233-7823.

I acknowledge that I have reviewed Nile orthopedic and Rehabilitation Association fee schedule and understand that if I have questions regarding this Notice I may contact the office at 25805 Barton Road Suite A106 Loma Linda, CA 92354, Phone 909-233-7823.

Indicated below are names of any Person(s) to whom I would like Nile Orthopedic and Rehabilitation Association, Inc. to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate “All” if appropriate).

| Name | Relation to Patient | Allowed Disclosure |
|---|---|---|
| | | |

**Patient Name _____Patient Signature_____**

Date:_____

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Patient Name: _____ Account#_____

**MEDICAL CONSENT**

The undersigned consents to any x-ray examination, laboratory procedure and medical treatment rendered the patient under the general or special supervision of, or upon the advice of a physician.

_____ (Initial)

**RELEASE OF THE INFORMATION**

To extent necessary to determine liability for payment and to obtain reimbursement to Nile Orthopedic and Rehabilitation Association, Inc. portions of the patient's records prescription, including the patient's medical records may be disclosed to any person or corporation (or any agent of such person or corporation) which is or may be liable for all or any portion of changes by Nile Orthopedic and Rehabilitation Association, Inc. (including but not limited to insurance companies, health care service plans, worker's compensation carriers and employers.)

_____ (Initial)

**ASSIGNMENT OF BENEFITS**

I hereby authorize and direct payment of my insurance benefits (otherwise payable to me) to Nile Orthopedic and Rehabilitation Association, Inc. Payment shall not exceed the group's regular charges for treatment. I understand that I am financially responsible to the medical group for charges not covered by this authorization. This authorization is valid for all family members who received medical treatment.

_____ (Initial)

**FINANCIAL AGREEMENT**

In consideration of the service to be rendered to the patient, the undersigned agrees, whether they sign as patient, as agent, or as financially responsible party, to pay all charges for patient's care to Nile Orthopedic and Rehabilitation Association, Inc. In accordance with the medical groups current rates and terms. (ALL CHARGES ARE DUE AND PAYABLE AT THE TIME OF SERVICE.)

_____ (Initial)

**AUTHORIZATION TO TRANSFER FUNDS**

Should a credit balance appear on my account with Nile Orthopedic and Rehabilitation Association, Inc. during the course of my care, I authorize use of the credit balance to be applied to any unpaid balance due Nile Orthopedic and Rehabilitation Association, Inc for which I have accepted responsibility.

_____ (Initial)

**Medication and other History**

You consent for our office to retrieve your medication, laboratory and other medical history as needed to facilitate your medical care

_____ (Initial)

The undersigned certifies that they have read the foregoing, received a copy of the same and accepts all its terms and conditions.

Patient Signature or Patient's Agent or Representative_____

Patient Name (Print)_____ Date_____

Witness_____

a) If a patient is a minor, the parent, having legal custody, a legal guardian, or a person authorized by them in writing, must sign b) If patient is incompetent, legal guardian or conservator must sign

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## PATIENT'S RIGHTS AND RESPONSIBLITIES

To comply with the federal regulations (HIPAA), this office has established procedures to make your identity and medical records more secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record a signed acknowledgement that you have read your rights and responsibilities as patients and that you understand them. Please contact the offices staff if you have any question.

### PATIENT'S RIGHTS

- To receive service within a reasonable period of time.
- To receive medically necessary service.
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risk and options.
- To have your medical coverage explained to you.
- To have all medical and personal records treated as confidential.
- To participate in treatment decisions.
- To refuse treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical records subject to legal restrictions and reasonable copying charges.
- To request review of your medical records by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.
- To formulate an advance directive if you have a life threatening illness or injury.
- To provide, or have provided for you, an interpreter in your primary language.

### PATIENT'S RESPONSIBILITIES

- Having appropriate identification, insurance membership cards, coverage stickers, etc. at the time of the appointment.
- Fulfilling financial obligations at the time of the service such as deductible or co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship of minor being treated.
- Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.

Please sign and return this form to the front desk.
*If you prefer a longer version, you may request one.

Patient's Signature_____ Date_____

Print Name _____ Account Number_____