PLEASE PRINT

Dr. David Liao Orthopaedic Center, LLC

REGISTRATION FORM

PATIENT INFORMATION

Patient Name ______________________ **Birthdate** ____________ Age ______

Mailing Address ______________________ Home/Cell Phone ____________

City/State/Zip ______________________ Email (optional) ____________

Soc. Sec # _____–_____–_____ Marital Status ____________ Sex [ ] Male [ ] Female

Occupation ____________ Employer ____________

Employer's Address ______________________ Work Phone ____________

Spouse's Name ____________ DOB ___/___/___ Soc. Sec # _____–_____–_____

Employer ______________________ Work Phone ____________

In Case of Emergency Please Contact ____________ Phone ____________

Referred by ______________________ Phone ____________

Drug Allergies ______________________

PARENT / GUARDIAN INFORMATION IF PATIENT IS A MINOR

Father/Guardian Name ____________ DOB ___/___/___ Soc. Sec # _____–_____–_____

Address (if different from patient) ______________________

City ____________ State______ Zip ______ Home Phone ____________

Employer ______________________ Phone ____________

Mother/Guardian Name ____________ DOB ___/___/___ Soc. Sec # _____–_____–_____

Address (if different from patient) ______________________

City ____________ State______ Zip ______ Home Phone ____________

Employer ______________________ Phone ____________

HEALTH INSURANCE (PLEASE PRESENT YOUR CARD TO RECEPTIONIST)

Primary Insurance ______________________ Phone ____________

Address ______________________ City ____________ State _____ Zip ______

Insured Name ____________ Soc. Sec # _____–_____–_____ DOB ___/___/___

Policy ID # ____________ Group # ____________

Secondary Insurance ______________________

Address ______________________ City ____________ State _____ Zip ______

Insured Name ____________ Soc. Sec # _____–_____–_____ DOB ___/___/___

Policy ID # ____________ Group # ____________

ACCIDENT INFORMATION (IF APPLICABLE)

Date of Accident ____________ Worker's Compensation [ ] or Auto Accident [ ] or Other [ ]

Part of Body Injured ____________ Where did Accident Happen? ____________

Explain how? ______________________ Insurance____________

Address ______________________ City ____________ State _____ Zip ______

Claim or Policy # ____________ Name of Adjuster ____________

Employer (if different from above) ______________________ Phone____________

ASSIGNMENT , RELEASE OF INFORMATION AND CANCELLATION POLICY

NOTE: Assignment and Release of Information: I hereby authorize Dr. David Liao Orthopedic Center to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to Dr. David Liao. I understand that I am responsible for any amount not covered by insurance and that if my account is turned over for collections, the fee will be my responsibility. Cancellation Policy: I understand 24 Hours Notice is required for all appointments and 7 Days Notice is required for all surgeries. The penalty for not canceling with proper notice is $25.00 for office appointments and $250.00 for surgeries. ***By signing below, I recognize and accept responsibility for any balance remaining after payment of benefits, and acknowledge cancellation policies.***

______________________ ____________ ____________

Signature of Responsible Party Relationship to Patient Date

CONSENT TO TREAT

I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a provider of Dr. David Liao Orthopaedic Center, LLC.

______________________ ____________ ____________

Signature of Responsible Party Relationship to Patient Date

OVER

HIPPA - Release of Information

I have acknowledged and / or received a written copy of the "Notice of Privacy Practices" and "Patient Bill of Rights".

Patients Name: Last _______________, First ______________ Middle __________Date of Birth: ______________

I hereby give permission to Dr David Liao Orthopaedic Center, LLC and/or involved medical staff to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friends. Please note our office will automatically release information to your listed primary care physician upon request.

Name: ___________________________________ Relationship: ______________________________

Name: ___________________________________ Relationship: ______________________________

Name: ___________________________________ Relationship:______________________________

_______ Intial here if you DO NOT authorize assignments of any person(s) to communicate with Dr. David Liao Orthopaedic Center, LLC and/or involved medical staff for any Reason.

Patient / Representative Print Name: ____

Patient / Representative Signature: ____ Date: ____________________

Patient Consent

1. I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by Dr. David Liao Orthopaedic Center, LLC. I am aware that the practice of medicine and other healthcare professionals is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations.
2. I consent to the use and disclosure of my / the patients protected health information for the purposes of obtaining payment for services rendered to me/the patient, treatment and healthcare operations consistent with the Dr. David Liao Orthopaedic Center, LLCs privacy practices.
3. I authorize payment of medical benefits to Dr. David Liao Orthopaedic Center, LLC.
4. I give permission to obtain all my medication/ prescription history when using an electronic system to process prescriptions for my medical treatment.

Patient / Representative Signature: ____ Date: ______________________

Appointment / Surgery Reschedule, Cancellation and No Show Policy

We understand that situations arise in which you must cancel or reschedule your appointment. It is requested that if you must cancel or reschedule your appointment that you provide at least 24 Hours Notice and that if you must cancel or reschedule your surgical procedure that you give at least 7 Days Notice.

Office appointments which are canceled or rescheduled with less than 24 hours notification may be subject to a $25.00 fee. Surgical Procedures which are canceled or rescheduled with less than 7 days notice may be subject to a $250.00 fee. This fee will be required to be paid in full prior to another appointment being scheduled for the patient.

Patient who do not show up for their appointment or procedure and do not call to cancel or reschedule their appointment will be considered a NO SHOW. Patients who no show two (2) or more times in a 12 month period, may be dismissed from the practice and denied any future appointments. Patients that no show will also be subject to the $25.00 appointment cancellation fee and the $250.00 surgical cancellation fee.

I have read these policies and agree that they are an established part of this practice:

Patient / Representative Signature: ____ Date: ________________________

Dr David Liao Orthopaedic Center, LLC

Narcotics Agreement

The terms of this agreement / contract include the following:

Only one pharmacy will be used for filling narcotic prescriptions,

The pharmacy you have selected is: ____

City: _______________________________________ Street Address: __________________________________

1. If it is found that I received a prescription for narcotic medications from a source other than Dr David Liao, I will be discharged from Dr. David Y. Liao, D.O. Orthopedic Center, LLC and any prescriptions for narcotic medication will be discontinued.
2. I agree to take the medication exactly as prescribed by Dr. David Liao. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without prior approval from Dr David Liao or a staff member.
3. I agree that Dr David Liao will NOT replace any lost, stolen, or inaccessible narcotic medications or narcotic prescription for any reason.
4. I must keep all regular follow up appointments as recommended. Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from Dr David Y. Liao, D.O. Orthopedic Center, LLC.
5. I agree to comply with random urine, blood, saliva or breath testing to document the proper use of medica tions.
6. I will not drive a motor vehicle or operate heavy machinery while impaired.
7. I understand that driving a motor vehicle may not be allowed while taking controlled substances and it is my responsibility to know and comply with state laws.
8. I have been given information about the use of narcotic medications and possible risks of side effects including development of tolerance, dependence, addiction, and withdrawal problems due to the medications and I agree to undergo narcotic administration.
9. I agree to NOT hoard medication or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from Dr. David Y. Liao, D.O. Orthopedic Center, LLC.

I agree to the following: a) That I am NOT currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance dependence or abuse. b) That I have never been involved in the sale, illegal possession or transport of any drugs. c) For Women: That I am not pregnant and that I will inform the physician immediately should I become pregnant.

This form has been fully explained to me. I have read it or have had it read to me, and I understand and agree to the terms of this contract. By signing below I understand I am also authorizing Dr David Liao Orthopaedic Center, LLC, David Y. Liao, D.O. and staff to obtain and review my prescription history (this will help insure any medication given will not counteract with any current medication and to obtain current medications and dosages). If any part of this contract as outlined above is broken I understand that it will result in the immediate discharge from Dr. David Y. Liao, D.O. Orthopedic Center, LLC, and discontinuation of narcotic prescriptions.

Patient / Representative Print Name: ____

Patient / Representative Signature: ____ Date: ______________________

Financial Policy and Disclosure

Dr. David Liao Orthopaedic Center, LLC strives to collect the appropriate copay, deductible and coinsurances, all payments are due at the time of your visit or prior to your surgical procedure.

In some cases it is not possible to determine the exact amount of financial liability the patient will have. Dr. David Liao Orthopaedic Center LLC has a formula we use to estimate the amount we expect the patient will be responsibile for according to the insurance benefits. Benefits are verified routinely.

Please be advised that the amount we collect at any given time may be an estimate based on the information available at the time the insurance benefits were verified. It is possible that your insurance company will deem a different amount due by you than what was initially collected. If we received an explanation of benefits from your insurance company that reflects a higher amount due from you, we will be obligated to collect the remaining amount. If we estimate and collect more than what your insurance deems due, we will refund the overpayment to you.

We may not reduce, waive or otherwise forgive any amounts due. Our managed care contracts stipulate that it is our responsibility to collect the amounts due as deemed by your insurance plan coverage.

Please provide the front office with updated insurance, address, phone, and other changes at the first appointment after the change. Failure to provide this information may results in unnecessary patient liability for payment.

Patient / Representative Print Name: ____

Patient / Representative Signature: ____ Date: ______________________

Dr. David Liao Orthopaedic Center, LLC - Medical History

Todays Date: __________________

Patient Name: ___________________ DOB: _________

OCCUPATION: _____________________ Have you discontinued work?_________ If so, when? ___________

PRESENT CONDITION:

A. What is your chief complaint? (the reason you made your appointment, limited to one area per visit please)

____

On what date did this occur? If there was no injury, for how long have you had these symptoms?

____

Is this a work related injury? YES NO Is this injury related to an auto accident? YES NO

B. Please mark your primary complaint:

Loss of: ☐ Function ☐ Motion ☐ Strength

Pain with: ☐ Walking ☐ Sleeping ☐ Standing ☐ Sitting ☐ Sports ☐ Reaching ☐ Lifting ☐ Work ☐ Motion

Other:__________________ Is your pain constant or intermittent? ___________________________

C. What makes your symptoms worse?

☐ Sitting ☐ Standing ☐ Bending ☐ Walking ☐ Reaching ☐ Other – please specify_________________

D. What eases your symptoms?

☐ Sitting ☐ Standing ☐ Ice ☐ Heat ☐ Rest ☐ levation ☐ Bracing / Wrapping ☐ Other – please specify________________

E. What is the quality of your pain? ☐ Mild ☐ Moderate ☐ Severe

F. On a scale of 0-10 what is your pain today? _________

G. How would you describe your pain? ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐Shooting ☐Throbbing ☐Spasms

H. What symptoms are associated with your complaint?

☐ Swelling ☐ Locking ☐ Popping ☐ Grinding ☐ Redness ☐ Fever ☐ Weakness ☐ Loss of range of motion

☐ Other ______________________________ ☐Numbness / Tingling ☐Radiating Pain Explain: __________________

I. Have you received any injections for these symptoms? ☐ YES ☐ NO If yes, on what date? ____________ By: ___________

The injection provided: ☐ Good relief ☐ Some relief ☐ No relief

J. Have you had physical/occupational therapy for your symptoms/injury? ☐ YES ☐ NO If yes, when? _____________________

K. How much do your symptoms interfere with your activities?

Daily Activities of Living:

☐ None ☐ Rarely ☐ Often

☐ Most of the time ☐ Always

Extra-curricular:

☐ None ☐ Rarely ☐ Often

☐ Most of the time ☐ Always

Have you been treated by any other physicians for this? If so Whom? ________________________________ When? __________________

What tests have been performed? ☐ X-ray ☐ MRI ☐ EMG ☐ CT ☐ Bone scan ☐ Other______________________

What Facility were these tests performed at? ____________________________________ City? ___________________ When? ________

Please List All Medications You Are Taking (including non-prescription)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

ALLERGIES-(please fill in the boxes that apply)

☐None ☐Codeine ☐Fentanyl ☐Penicillin ☐Propofol/Diprivan ☐IV Contrast Dye ☐Eggs ☐Aspirin ☐Demerol ☐Morphine ☐Sulfa

☐Versed ☐Latex ☐Methimazole ☐Propylthiouracil

☐Other____

ARE YOU ON ANY OF THE FOLLOWING BLOOD THINNERS? (CHECK ALL THOSE THAT APPLY)

☐ ASPIRIN ☐ PLAVIX ☐ EFFIENT ☐ AGGRENOX ☐ WARGARIN/COUMADIN ☐ PRADAXA ☐ XARELTO

☐ OTHER: ____

SOCIAL HISTORY:

MARITAL STATUS:

☐ Single ☐ Married

☐ Widowed ☐ Divorced

☐ Separated

☐ Same-Sex Partner

ALCOHOL HISTORY:

☐ Never

☐ Occasional

☐ Less than 7 drinks/day

☐ More than 7 drinks/day

☐ Quit alcohol

RECREATIONAL DRUGS:

☐ Never

☐ In the past

☐ Currently using

☐ In treatment

TOBACCO STATUS (Smoking):

☐ Never

☐ Quit tobacco

☐ Less than 1 pack/day

☐ 1 pack/day ☐ 2-4 pack/day

☐ Never

☐5+ pack/day

Age started: _____________

Years used: _____________

Chewing:

Patient Name: ____________________________ DOB: ___________ **Height: _____________**

Date: ________________ **Weight: _____________**

RECENT SYMPTOMS-(please check current problems)

CONSTITUTIONAL:
- ☐ Fever
- ☐ Diminished
- ☐ Activity Fatigue

RESPIRATORY:
- ☐ Cough
- ☐ Bark-like cough
- ☐ Wheezing
- ☐ Chest Tightness Pain with Respiration Noisy
- ☐ Breathing Rapid
- ☐ Respirations Difficulty Breathing

MUSCULOSKELETAL:
- ☐ Soft Tissue
- ☐ Swelling Joint Swelling
- ☐ Myalgia
- ☐ Limited Motion
- ☐ Previous Injuries
- ☐ Trauma
- ☐ Other__________

SKIN:
- ☐ Pain
- ☐ Itchiness
- ☐ Dry Skin
- ☐ Flaking
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Skin Lesions
- ☐ Bruising
- ☐ Insect Bites

NEUROLOGIC:
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Burning
- ☐ Shooting Pain
- ☐ Dizziness
- ☐ Loss of Consciousness

PAST MEDICAL ILLNESSES-(please circle those that apply)

- ☐ AIDS/HIV
- ☐ Abdominal Pain
- ☐ Abuse/Domestic Violence
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Aneurysm
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Diseases
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Carpal Tunnel Disorder
- ☐ CHF-Congestive Heart
- ☐ Failure Coronary Artery
- ☐ Disease DVT
- ☐ Degenerative Joint Disease
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetic Retinopathy
- ☐ Emphysema/COPD
- ☐ Encephalitis
- ☐ Fibromyalgia
- ☐ Heart Attack
- ☐ Heart Disease/Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypercalcemia
- ☐ Hyperlipidemia
- ☐ Hypertensive Cardiovascular
- ☐ Disease Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Ischemic Neurologic Deficit
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ MRSA / Staph Infection
- ☐ Obesity
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Other: __________________
- ☐ Pancreatitis
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Post Menopause
- ☐ Prostate Disease
- ☐ Seizure/Epilepsy
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcer

PAST SURGICAL HISTORY (please put date by procedure):

____

____

FAMILY HISTORY (please list which member):

	Mother	Father	Bro.	Sis.	Grandparents
Colon Cancer/Polyps:	_____	_____	_____	_____	_______
Breast Cancer:	_____	_____	_____	_____	_______
Heart Disease:	_____	_____	_____	_____	_______
Liver Disease:	_____	_____	_____	_____	_______
Kidney Disease:	_____	_____	_____	_____	_______
Crohn's/Ulcerative Colitis:	_____	_____	_____	_____	_______
Thyroid Disorder:	_____	_____	_____	_____	_______
Other: _________	_____	_____	_____	_____	_______
_______________	_____	_____	_____	_____	_______
_______________	_____	_____	_____	_____	_______

Who is your Primary Care Provider: ____________________________________ Telephone Number: ___________________________

Who is your Cardiologist (Heart Doctor): ________________________________ Telephone Number: ___________________________

Who is your Pulmonologist (Lung Doctor): ______________________________ Telephone Number: ___________________________

Who is your Pain Management Provider: ________________________________ Telephone Number: ____________________________

Are you currently under the care of any other specialty provider? ______ Is so whom? ____