Email Address _____

Last Name_____

First Name_____

Previous Name_____

Address_____

City_____

State_____ **Zip**_____ **Country**_____

Social Security _____- _____- _____

Home Phone _____-_____-_____

Cell Phone _____-_____-_____

Work Phone _____-_____ -_____ **Ext** ____

Drivers License _____**State** ____

Responsible Party

__**SELF** (use info above) **-OR-**

Name_____

Address_____

City_____ State___Zip_____

Phone Numbers

Home _____-_____-_____
Cell_____-_____-_____
Work_____-_____-_____ Ext_____

Relation to Patient_____

Emergency Contact

Name_____

Address_____

City_____ State____ Zip_____

Phone Numbers

Home _____-_____-_____
Cell_____-_____-_____
Work_____-_____-_____ Ext._____

Relation to Patient_____

PATIENT INFORMATION FORM

RICHARD L. MALINICK, M.D.
ORTHOPAEDIC SURGERY
1125 Via Verde, San Dimas, CA 91773
909-592-8170

Date _____

Primary Care Physician_____

Referred by _____

Date of Birth _____

Sex (Please check box below)

- ☐ **Male**
- ☐ **Female**

Marital Status (Please check one)

- ☐ Single
- ☐ Married
- ☐ Partner
- ☐ Divorced
- ☐ Legally separated
- ☐ Widowed
- ☐ Unknown

Employer Name _____

Address _____

City_____ State____ Zip_____

Employment Status: (Please check one)

- ☐ Full-time
- ☐ Part-time
- ☐ Self-employed
- ☐ Not employed
- ☐ Retired
- ☐ Active Military Duty
- ☐ Reserved for national assignment
- ☐ Unknown

Student Status: (Please check one)

- ☐ Full-time
- ☐ Part-time
- ☐ Not a student

Insurance

Primary Insurance_____

Subscriber No._____

Group No._____

State_____

Insured's Name_____

Insured's Phone_____-_____-_____

Relation to Insured_____

Secondary Insurance_____

Subscriber No._____

Group No._____

State_____

Insured's Name_____

Insured's Phone_____-_____-_____

Relation to Insured_____

Race (please check one)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Other Pacific Islander
- ☐ Refuse to Report

Ethnicity (please check one)

- ☐ Hispanic or Latino
- ☐ *Not* Hispanic
- ☐ Refuse to Report

Preferred Language (please check one)

- ☐ English
- ☐ Spanish
- ☐ Other_____

Preferred Pharmacy

Name _____

Street _____City_____

Phone_____

Preferred Time to Leave Message (Please check one)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

Permissions

I grant permission for **Richard L. Malinick, M.D.** to leave messages at the following phone number.

_____-_____-_____

Type:

__ Home
__ Work
__ Cell

Also, contact me by….

__ Email
__ Text

Cell Phone Provider_____

(you won't be charged for the text message)

X_____ **Date**_____

Patient or Authorized Person's Signature

I grant permission for **Richard L. Malinick, M.D.** to view my Prescription History from external sources.

X_____ **Date**_____

Patient or Authorized Person's Signature

Financial Responsibility /Assignment of Benefits Form / HIPAA/ Fees

I understand that by signing this form, I am authorizing the following:

Financial Responsibility

I have requested medical services from **Richard L. Malinick, M.D**. on behalf of myself and/or my dependents, and I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and I agree to pay all such charges incurred in full, immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled to Richard L. Malinick, M.D. I hereby authorize and direct my insurance carrier(s), **including Medicare, private insurance and any other health/ medical plan,** to issue payment check(s) directly to **Richard L. Malinick, M.D., 1125 Via Verde Ave., San Dimas, CA 91773-4400** for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Richard L. Malinick, M.D** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. Medical Authorization for Release / Disclosure of Protected Health Information / HIPAA Privacy Notice has been provided.

Required 24-Hour Cancellation Notice

I understand that if I do not call and cancel my appointment with **Richard L. Malinick, M.D** at least 24 hours prior to my appointment time, I will be charged a $50 late cancellation fee.

X_____ Date _____

Patient or Authorized Person's Signature

Confidentiality Agreement

I authorize **Richard L. Malinick, M.D. and staff to** provide and/or discuss my care and medical needs with the following individuals.

	Name	**Relation**	**Phone**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

X_____ Date_____

Patient or Authorized Person's Signature

rev.8/27/14

Richard L. Malinick, M.D.
Adult History Form

Please fill out form completely:
Date:_____Patient Name:_____Age:_____

Reason for today's visit: _____

Medication: (including supplements, herbals, and over-the-counter):

Medication name	Dosage	How many pills	How often

Medical History: Please list any medical problems: _____
_____

Allergies:

Medication name	Reaction

Surgeries:

Date	Surgical Procedure

Hospitalizations: (other than surgeries listed above, for example: pneumonia, childbirth, etc.)

Date	Reason

Family History:

Father:___Alive____Age **OR** _____Deceased____Age (at death) **OR** ___Unknown
History of: ____Diabetes ____Arthritis____Cancer____Heart Disease____other (please list)

Mother:___Alive____Age **OR** _____Deceased____Age (at death) **OR** ___Unknown
History of: ____Diabetes ____Arthritis____Cancer____Heart Disease____other (please list)

Please fill out form completely:

Social History:

Tobacco use (please check one):

_____Current every day smoker
_____Current some day smoker
_____Former smoker
_____Never smoker
_____Smoker, current status unknown
_____Unknown if ever smoked

Have you had a drink within the last year? _____Yes _____No
Do you use illicit or recreational drugs? _____Yes _____No

Occupation:_____

Preventative Medicine: Date (year) of last tetanus:_____
Date of last pneumococcal vaccine:_____ Date of last flu shot:_____
Date of last DEXA (if female):_____Location:_____

Do you have or have you ever had or been treated for any of the conditions listed below?
Only place a check if your answer if "Yes"

____Weight loss
____Fever
____Chills
____Fatigue
____Penicillin allergy
____Latex allergy
____AIDS
____Double vision
____Eye infection

____Ear infection
____Sore throat
____Diabetes
____Thyroid disease
____Steroid use
____Tuberculosis
____Asthma
____Shortness of breath
____Pneumonia

____Chest pain
____High blood pressure
____Heart attack
____Gallstones
____Stomach ulcers
____Chronic diarrhea
____Hepatitis
____Bleeding tendencies
____Blood clots
____Cancer

____Urinary tract infection
____Kidney infection
____Frequent urination
____Kidney stones
____Blood in urine
____Painful urination
____Incontinence
____Fracture
____Dislocation
____Rheumatoid arthritis
____Gout
____Lupus

____Rashes
____Bruise easily
____Numbness
____Tingling
____Seizures
____Stroke
____Severe Headache
____Migraine headaches
____Depression
____Sleeplessness
____Mood swings

Patient Signature:_____Date:_____