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.
CHILDREN'S HISTORY

PLEASE FILL OUT COMPLETELY DATE: _____

PATIENT NAME:_____ AGE:_____

REASON FOR TODAY'S VISIT: _____

_____

_____

ALLERGIES(drugs, food and environmental): _____
MEDICATION (including herbal and over the counter): _____
_____

IMMUNIZATIONS: ARE THEY CURRENT? (Y FOR YES AND N FOR NO)
DPT:____ HEP. B: ____ POLIO: ____ MMR: ____ HIB: ____

BIRTH WT: _____ TYPE OF DELIVERY: C-SECTION:____ VAGINAL: ____
COMPLICATIONS OF PREGNANCY OR DELIVERY: _____

PLEASE LIST ALL HOSPITALIZATIONS AND SURGERIES:
DATE ILLNESS/SURGERY PHYSICIAN

_____
_____
_____
_____

MOTHER: AGE: ____ ANY MEDICAL PROBLEMS? _____
FATHER: AGE: ____ ANY MEDICAL PROBLEMS? _____
SIBLINGS: MALE:_____ FEMALE: _____ AGES: _____
ANY FAMILY HISTORY OF:
DIABETES: ____ ARTHRITIS: _____ SCOLIOSIS: ____ CLUBFEET: ____
HIP DISLOCATIONS: ____ OTHER: _____

(TURN PAGE OVER)

CHILDREN'S HISTORY

DOES THE PATIENT HAVE ANY OF THE FOLLOWING?
(Y FOR YES AND N FOR NO)

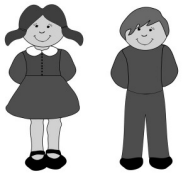
WEIGHT LOSS___
FEVER___
CHILLS___
DOUBLE VISION___
EYE INFECTION___
EAR INFECTION___
CHRONIC SORE THROAT___
CHEST PAIN___
HIGH BLOOD PRESSURE___
HEART ATTACK___
TUBERCULOSIS___
ASTHMA___
SHORTNESS OF BREATH___
PNEUMONIA___
GALLSTONES___
STOMACH ULCERS___
CHRONIC DIARRHEA___
HEPATITIS___
URINARY TRACT INFECTIONS___
KIDNEY INFECTIONS___
FREQUENT URINATION___
KIDNEY STONES___
BLOOD IN URINE___
PAINFUL URINATION___

FRACTURE___
DISLOCATION___
RHEUMATOID ARTHRITIS___
GOUT___
LUPUS___
RASHES___
BRUISE EASILY___
NUMBNESS___
TINGLING___
SEIZURES___
SEVERE HEADACHES___
MIGRAINE HEADACHES___
LEARNING PROBLEMS___
DIABETES___
THYROID PROBLEMS___
STEROID USE___
BLEEDING TENDENCIES___
BLOOD CLOTS___
CANCER___
PENICILLIN ALLERGY___
LATEX ALLERGY___
AIDS___

ANY OTHER MEDICAL PROBLEMS:_____
_____

PARENT SIGNATURE: _____ DATE:_____

RICHARD L. MALINICK, M.D.
Child and Adult Orthopaedic Surgery
Diplomate of the American Board
of Orthopaedic Surgery



CONSENT TO TREAT A MINOR

Minor's Name _____Birthdate_____/_____/_____

Blood type _____Last tetanus injection_____

Child's pediatrician _____ Phone_____

Allergies to drugs or foods_____

_____

Physical conditions, special medication, or other info_____

_____

Parent or Guardians' name(s)_____

Address_____City_____State_____Zip_____

Mother's Home Phone _____Cell_____ Work_____

Father's Home Phone _____Cell_____ Work_____

Guardian's Home Phone _____Cell_____ Work_____

I (we) the parent(s) or guardian(s) of _____, a minor, do herby authorize and consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment to be rendered by Richard L. Malinick, M.D.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required and is given to provide consent to such care when the foregoing licensed physician in his best judgment deems it advisable. It is understood that Richard L. Malinick, M.D. and his staff shall attempt to contact the undersigned and the physician indentified above, if one is noted, prior to rendering treatment to the minor. However, treatment will not be withheld if the undersigned cannot be reached.

I (we) hereby authorize Dr. Richard Malinick to surrender physical custody of my (our) minor to the individual who presented the minor for treatment upon completion of the treatment if I (we) are not present on said minor's release.

Mother's Signature _____ Date _____/_____/_____

Father's Signature _____ Date _____/_____/_____

Guardian's Signature _____ Date _____/_____/_____

Consent shall remain in effect until age 18 or_____/_____/_____

1125 Via Verde San Dimas, California 91773 (909) 592-8170 FAX: (909) 599-0750