

Edward Diao, M.D.
 Orthopaedic Surgery/ Sports Medicine
 Hand, Upper Extremity and Microvascular Surgery

New Patient Information Sheet

Patient's Name: Last Name		First Name		Date of Birth	Age
Home Address: #	Street	Apt #	City	State	Zip
Home Phone: ()		Cell Phone: ()		Work Phone: ()	
E-mail:			Social Security #		Gender: M F
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Spouse/Partner :					
Ethnicity:		Race:		First Language:	
Emerg. Contact:		Relationship:		Phone: ()	
Employment Information: Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No Last worked date:					
Employer:			Occupation:		
Referring MD:			Primary MD:		
MD PHONE:		MD FAX:		MD PHONE:	
MD FAX:		MD PHONE:		MD FAX:	
Primary Insurance: _____ <input type="checkbox"/> None			Secondary Insurance: _____ <input type="checkbox"/> None		
Name of Insured:			Name of Insured:		
DOB of Insured:			DOB of Insured:		
Relationship to Patient:			Relationship to Patient:		
Patient's Current Injury					
Which is your DOMINANT hand? <input type="checkbox"/> Right <input type="checkbox"/> Left		What is your HEIGHT ?		What is your WEIGHT ?	
What part of your body is/was injured?					
How did your problem develop ? <input type="checkbox"/> Over time <input type="checkbox"/> It was an injury					
What is the DATE and PLACE of Injury?					
Describe HOW the injury happened (briefly):					
How do your symptoms limit your ability to perform work duties ?					
Do your symptoms affect your activities of daily living ? If so, explain.					
Do you have any numbness and/or tingling ? If so, where?					
Do your symptoms keep you awake at night? If so, explain.					
Have you noticed any weakness ? If so, explain.					
Please describe any TREATMENT you have had for the present problem.					
Patient Past Medical And Surgical History					
List all MEDICAL PROBLEMS you have: <input type="checkbox"/> None			List all SURGERIES you have had: <i>Indicate year and procedure</i> <input type="checkbox"/> None		

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List all of the current MEDICATIONS / HERBAL TREATMENTS / SUPPLEMENTS that you are taking. Including the DOSAGES . <input type="checkbox"/> None			
List all ALLERGIES you have (include name of medication and reaction): <input type="checkbox"/> No Known Allergies <input type="checkbox"/> No Known Drug Allergies			
Patient Social History			
What are your hobbies/interests?			
Alcohol consumption: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Socially <input type="checkbox"/> Daily If so, how many drinks/week? _____			
Cigarette use: <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current # _____ per day, for _____ years If you have quit, how long ago? _____			
Patient Health Review (Do you have any of the following? If yes, please specify)			
GENERAL	SKIN		
Have you been in good general health most of your life? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Skin disease <input type="checkbox"/> Hives <input type="checkbox"/> Eczema <input type="checkbox"/> Frequent infections or boils		
Any allergies, including medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Jaundice <input type="checkbox"/> Abnormal pigmentation <input type="checkbox"/> Rash		
Any recent weight gain? <input type="checkbox"/> Yes <input type="checkbox"/> No	GASTROINTESTINAL		
HEAD, EYES, NOSE, THROAT	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Vomiting blood or food <input type="checkbox"/> Gallbladder disease		
<input type="checkbox"/> Eye diseases or injury <input type="checkbox"/> Wear glasses <input type="checkbox"/> Double vision	<input type="checkbox"/> Liver trouble <input type="checkbox"/> Heartburn or indigestion <input type="checkbox"/> Frequent Diarrhea		
<input type="checkbox"/> Itchy eyes or nose <input type="checkbox"/> Headaches <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Black Stools <input type="checkbox"/> Recent changes in bowel habits <input type="checkbox"/> Hemorrhoids or piles		
<input type="checkbox"/> Ear Disease <input type="checkbox"/> Impaired hearing	GENITOURINARY		
<input type="checkbox"/> Runny nose <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Chronic sinus trouble	<input type="checkbox"/> Loss of urine or Frequent urination <input type="checkbox"/> Night time urinating		
<input type="checkbox"/> Dizziness or transient episodes of unconsciousness?	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney trouble/ Stone		
LOCOMOTOR - MUSCULOSKELETAL	CARDIOVASCULAR		
<input type="checkbox"/> Varicose veins <input type="checkbox"/> Weakness of muscle or joints	<input type="checkbox"/> Shortness of breath with walking or lying down <input type="checkbox"/> Heart murmur		
<input type="checkbox"/> Difficulty walking <input type="checkbox"/> Pain in calves or buttocks on walking, relieves by rest?	<input type="checkbox"/> Swelling of hands, feet or ankles <input type="checkbox"/> High blood pressure		
RESPIRATORY	<input type="checkbox"/> Chest pain or angina pectoris <input type="checkbox"/> Heart trouble or heart attacks		
<input type="checkbox"/> URI (cold) now <input type="checkbox"/> Spitting up blood	NEURO - PSYCHIATRIC		
<input type="checkbox"/> Chronic of frequent cough <input type="checkbox"/> Asthma or wheezing	<input type="checkbox"/> Ever been advised to see a psychiatrist or had psychiatric care		
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Fainting spells <input type="checkbox"/> Convulsions <input type="checkbox"/> Paralysis		
ENDOCRINE	HEMATOLOGICAL		
<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Blood disease <input type="checkbox"/> Anemia <input type="checkbox"/> Phlebitis		
<input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Any changes in hat or glove size	<input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Bleeding excessively after tooth extraction or surgery		
NECK	IMMUNE		
<input type="checkbox"/> Stiffness / Numbness <input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Arthritis <input type="checkbox"/> Have HIV/AIDS <input type="checkbox"/> Any known hematologic condition		
<input type="checkbox"/> Enlarged Glands <input type="checkbox"/> Swelling of hands, feet or ankles			
Family Health Review (Has any blood relative ever had any of the following?) <input type="checkbox"/> M = Maternal / Mother, <input type="checkbox"/> P = Paternal / Father			
Cancer <input type="checkbox"/> M <input type="checkbox"/> P	Suicide <input type="checkbox"/> M <input type="checkbox"/> P	Stroke <input type="checkbox"/> M <input type="checkbox"/> P	Tuberculosis <input type="checkbox"/> M <input type="checkbox"/> P
Diabetes <input type="checkbox"/> M <input type="checkbox"/> P	Heart Trouble <input type="checkbox"/> M <input type="checkbox"/> P	High Blood Pressure <input type="checkbox"/> M <input type="checkbox"/> P	Mental Illness <input type="checkbox"/> M <input type="checkbox"/> P
Convulsions <input type="checkbox"/> M <input type="checkbox"/> P	Bleeding Tendency <input type="checkbox"/> M <input type="checkbox"/> P	Gout <input type="checkbox"/> Arthritis <input type="checkbox"/> M <input type="checkbox"/> P	Hereditary Defects <input type="checkbox"/> M <input type="checkbox"/> P

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Consent to Treatment

I hereby request and consent to treatment for **myself** or my **child**, here at the office of Edward Diao, M.D.

Authorization for Release of Medical Information

I authorize the release of any and all information acquired in the course of my examination and treatment of the purpose of securing payment of benefits for insurance company. A photocopy of this agreement is to be considered as valid as the original.

Assignment of Benefits

I hereby assign all surgical and/or medical benefits for services rendered; to be paid directly to the Office of Dr. Edward Diao will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Financial Policy

- Please be prepared to pay your co-payment at every visit. Your co-payment amount is usually indicated on your insurance I.D. card.
- Please be prepared to pay your deductible (if not met) and any co-insurance amount at the time of your visit.
- Please bring your current insurance I.D. card to every appointment. If you arrive for your appointment and we are unable to verify your insurance coverage or authorization, you may reschedule your appointment to a later date, or you may elect to keep your appointment that day, but will be required to pay for the visit. If you keep your appointment, we will make a reasonable attempt to bill your insurance and request a refund directly to you.
- If your insurance requires authorization from your primary care physician, please make sure that you have one that is valid for your visit and that it covers any necessary tests needed.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.
- We will do all we can to assist your with your health insurance claims, however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you.
- A returned check charge of \$25 will be charged to my account for each returned check.
- I acknowledge there will be a charge of \$50.00 for missed appointment or cancellation with less than 24 hours' notice.

Notice of Privacy Practice

Edward Diao, M.D. is committed to protecting the privacy of your medical and personal information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. Dr. Edward Diao, M.D. protects your personal and health information in electronic, written and oral forms when used throughout our organization. We may modify or change our privacy practices from time to time, particularly as new laws and regulations become effective. Any changes will be effective for all the personal and health information we maintain, even information in existence before the change. If we materially modify our privacy practices, we will provide you with a new notice advising you of the changes. So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

I have read and understand all the sections above.

Signature: _____ **Date:** _____

Out-of-Network Policy

I understand that Edward Diao, MD is not contracted with my insurance. I agree to make a partial payment or a deposit every visit. The fees are based on services provided on each visit, and can vary from visit to visit. This deposit will be based on a percentage of the total visit's fees. Dr. Diao's billing department will submit all charges to my insurance. My insurance company will render payment based on my health insurance policy. Once a determination is made by my insurance company, Dr. Diao's billing department will contact me to settle my account.

Signature: _____ **Date:** _____
(If applicable)

450 Sutter Street, Suite 910 , San Francisco, California 94108
Telephone: (415) 362-8880 * Fax: (415) 362-8045
www.edwarddiaomd.com

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CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medication (narcotics-opioids, tranquilizers, barbiturates, i.e. any drug which induces sleep or stupor) can be very useful, but have high potential for misuse or abuse and are, therefore, closely controlled by government agencies. Used properly, some of them can be very effective pain medicine. If used excessively, however, they can cause adverse effects, such as impaired judgment, vomiting, constipation, lethargy, organ damage, or even death. To ensure these medications are used properly, I agree to the following conditions.

1. I am RESPONSIBLE for my controlled substance medication. IF THE PRESCRIPTION OR MEDICATION IS LOST, STOLEN OR MISPLACED, OR IF I USE IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT WILL NOT BE REPLACED.
2. I will not request or accept narcotic medications from any other physician or individual while I am receiving such medications from Edward Diao, MD (except if I am in the hospital). Besides being illegal to do so (NRS 453.39 1), it may endanger my health.
3. I understand that there will be a 24 to 48 hour turnaround time for non-narcotic medication refills; therefore, I will not wait until my medication is gone to request more medication. Controlled substances may be obtained only during a scheduled office visit. Refills will not be made at night, on holidays, or on weekends.
4. I understand that if I violate ANY of the above conditions my controlled substance medication may be discontinued immediately. I am aware of "narcotic effects", including physiological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal may occur if I stop my medications abruptly) and the effects of addiction (psychological dependence), which is less common in patients with true pain. I also understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as an automobile. I must use special care while involved in activities requiring clear thought and concentration.

Signature of Patient/Guardian

Date signed

Witness Signature

Date Signed

DISCLAIMER: Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Edward Diao will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

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