



REGISTRATION

Physician/PCP _____ Referred by _____

Dr's Address _____

Dr's phone: () _____ Dr's fax: () _____

Name of patient: Last _____ First _____ Middle _____

Home address: Number _____ City _____ State _____ Zip _____

Home Phone: () _____ SS# _____ Cell _____

Date of birth _____ Age _____ Sex M F Driver's lic. _____

Employer _____ Occupation _____

Employer address: _____ City _____ State _____ Zip _____

Employer phone () _____

Insurance Name _____ I.D# _____

Policy Holder Name _____

Is this ins. Primary? Yes No Is there other coverage? _____

Name of spouse: Last _____ First _____ Middle _____

Date of birth _____ Driver's lic. _____

Employer _____ Occupation _____

Employer address: _____ City _____ State _____ Zip _____

Employer phone () _____

Details of injury/illness :

Date of Onset _____ Explain in detail (where, when, how) _____

I hereby authorize release of information necessary to file a claim with my Insurance company and assign benefits otherwise payable to: Adult and Pediatric Orthopaedic Specialists.

I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient/Responsible Party Signature _____ Date _____

PATIENT HEALTH INFORMATION FORM

Name _____ Date of Birth _____ Age _____ Sex M F

Phone: Home _____ Work _____ Cell _____

What is your current: Height _____ Weight _____

Have you ever had, or been told you had: blood transfusions Yes No When _____

Anesthetic reaction Yes No Surgical bleeding Yes No Bleeding from aspirin Yes No

Have you been hospitalized for non-surgical reasons? Attach a list if necessary

Reason for admission	Year	Hospital	Doctor

Any prior surgeries? Attach a list if necessary

Operation	Year	Hospital	Doctor

List all prescription medications you are now taking: Attach a list if necessary

Name	Dose	How often	Name	Dose	How often
1.			4.		
2.			5.		
3.			6.		

List all herbal/non prescription medications you are taking: Attach a list if necessary

1.	4.
2.	5.
3.	6.

Do you take vitamins? Yes No What? _____

Do you drink milk Yes No # Glasses/Day _____

Take calcium Yes No Dose _____ #/Day _____

Do you have allergies to:

Medications: list _____

Foods: list _____ Tape Yes No

Metal/Jewelry Yes No

Iodine Yes No

Latex Yes No

Do you have: Dermatitis Yes No

Eczema Yes No

Family History:

	If living		If deceased	
	Age	Health	Age	Cause
Mother				
Father				
Siblings				
Children				
Spouse				

In your blood family, is there a history of:

Cancer Yes No TB Yes No Muscle disease Yes No
Heart attack Yes No Diabetes Yes No High blood pressure Yes No
Seizures Yes No Suicide Yes No Stroke Yes No
Bleeding Yes No Kidney disease Yes No Arthritis Yes No
Gout Yes No Bone disease Yes No Congenital deformity Yes No
Osteoporosis Yes No Blood Clots Yes No

Personal History:

Married Single Divorced Widowed Living Situation: House ____ Apt. ____ Other ____
Occupation _____
Alcohol use: Yes No How much/Day _____ Tobacco use: Yes No
Recreational drug use? Yes No List _____
Industrial health hazards exposure Yes No List _____ HIV/AIDS Yes No

Health Review:

Have you had a dexa bone density scan? Yes No When? _____
Have you had a fall in the past year? Yes No How many _____
Unexplained fevers Yes No Unexplained weight loss Yes No Cancer Yes No
Have you had any of the following health problems? Check all that apply:

Head, Eyes, Ears, Nose, Throat:

Eye injury Yes No Deafness Yes No Hay fever Yes No
Nosebleeds Yes No Hoarseness Yes No Wear glasses Yes No
Earache Yes No Double vision Yes No Gland enlargement Yes No
Headache Yes No Dizziness Yes No Ear ringing Yes No
Glaucoma Yes No Seizures Yes No

Cardiovascular:

Angina Yes No Fast heart Yes No Varicose veins Yes No
Phlebitis Yes No Chest pain Yes No Short of breath Yes No
Jumping heart Yes No Heart disease Yes No Rheumatic fever Yes No
Ankle swelling Yes No Rheumatic fever Yes No Heart failure Yes No
High blood pressure Yes No Pulmonary embolism Yes No
Passing out with exercise Yes No Chest pain with exercise Yes No

Pulmonary:

Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pleurisy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No

Gastrointestinal:

Gallstones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appetite change	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vomit blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black stool	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hiatal hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Gynecologic:

Fibroids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ovarian cyst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular periods	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last menstrual period	_____		#Pregnancies	_____	
Hysterectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	At what age	_____		Do you take hormones <input type="checkbox"/> Yes <input type="checkbox"/> No

Genitourinary:

Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poor stream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain on urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain	_____		

Skin/ breast:

Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin color changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Scars	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	_____		

Hematologic/Lymphatic/Endocrine:

Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enlarged glands	<input type="checkbox"/> Yes <input type="checkbox"/> No

Psychological:

Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood swings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tearfulness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poor sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Angry outbursts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Addiction history	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Neurologic:

Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incoordination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Falling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech slurring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tingling hands or feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any other health problems that you are aware of?

Please explain _____

Signature _____ Date _____



Insurance Eligibility Certification HMO/PPO/POS

I hereby attest that I am an eligible member of a contracted health plan as noted below. I agree, that should it be determined that I am ineligible or services are denied to me under the health plan noted below, that I will be responsible for payment to:

Adult and Pediatric Orthopaedic Specialist

Health Plan _____

Plan ID _____

Name of Subscriber _____

Social Security Number _____

Name of Patient _____

Social Security Number _____

Relationship to Subscriber _____

I authorize release of my medical history and documentation directly to my insurance company for the purpose of payment for medical service and that the payment(s) be made directly to: ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS.

Signature _____

Date _____



ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment for services.
- Conduct normal health care operations.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at 714-633-2111 at any time to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient Name _____

Patient Representative _____

Signature _____ Date _____





OUR PRIVACY PROMISE TO YOU, OUR PATIENTS

YOUR INFORMATION IS IMPORTANT AND CONFIDENTIAL. OUR POLICIES REQUIRE THAT YOUR INFORMATION BE HELD IN COMPLETE CONFIDENCE.

Authorization to leave messages

I give my permission for the staff of Adult and Pediatric Orthopaedic Specialist to leave messages on my telephone answering machine or with a family member such as information regarding medication, surgery, appointments and healthcare.

Signature of Patient _____ Date _____

Patient Name - Please Print _____

Family Member's Name _____

Family Member's Name _____

I do not give my permission for the staff of Adult and Pediatric Orthopaedic Specialist to leave message on my telephone answering machine or with a family member such as information regarding medication, surgery, appointments and health care.

Signature of Patient _____ Date _____

Patient Name - Please Print _____



Consent for Electronic Mail (“Email”) Use

APOS (“Office”) offers patient the opportunity to communicate by Email for non-urgent matters. This form provides the guidelines regarding Email communications, and documents your consent.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911

- Email Use** Email communications should be between the office and an adult patient 18 years of age or older, or the parent or guardian of a minor.
- Do Not Use Email For** Do not use Email for communicating sensitive medical information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or presence of malignancy. Do not use Email to request records. Please call your office.
- Privacy, Security & Confidentiality** Although the office has implemented reasonable technical safeguards, the office cannot and does not guarantee the privacy, security or confidentiality of any Email messages sent or received over the Internet. There is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and / or read by others. The office is not responsible for Email messages that are lost due to technical failure during composition, transmission, or storage. The office will not forward Emails to independent third parties without your prior written consent, except as authorized or required by law. If any of this is a concern to you, you should not communicate with the office through Email.
- Creating a Message** In the “Subject” line of the email, please include general topic of your message (i.e., prescription, appointment, medical advice, billing question). In the body of the message, please include the patient’s name and date of birth. This information is necessary to verify your identity and make sure we pull the correct medical file.
- Content of the Message** Email should only be used for non-sensitive and non-urgent issues. Email communications are appropriate for the following type of transactions:
- Appointment scheduling
 - Prescriptions / refills
 - General medical advice after an initial face-to-face visit
 - Lab/Test Results
 - Referrals
 - Attachments such as: physical education excuse note, etc.
- Response Time** Although APOS will endeavor to read and respond within 24 hours to any Email, we cannot guarantee that any particular Email will be responded to within any particular period of time. If you have not received a response within 3 days, please call our office.
- Documentation In Medical Record** Email communications regarding treatment will be documented in your medical record by placing a copy of the message in your file.
- Ending Email Relationship** You may discontinue using Email as a means of communication by sending an email or letter to the office.

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email as one form of communication with the office.

Email Address: _____

Signature of Patient, Parent or Personal Representative

Date

Relationship (if other than patient)

PATIENT CONSENT AND WAIVER FORM

I, _____, understand that I am, or will be, responsible for all of the charges associated with my appointment today, as well as any subsequent appointments relating to the testing, x-rays, diagnosis, and all treatment, including, but not limited to the following items:

- 1. ALL DURABLE MEDICAL EQUIPMENT, IF NOT COVERED BY INSURANCE PLAN.**
 - 2. NO REFERRAL AT TIME OF VISIT:** If you wish to be seen today, but did not bring a referral with you, nor do you have a valid referral already here in the office, you will be responsible for all charges.
 - 3. NO INSURANCE:** You will be responsible for all charges associated with all visits.
 - 4. MISSED APPOINTMENTS:** Appointments are confirmed prior to your appointment date. If an appointment is cancelled up to 24 hours prior, you will not be charged. If you fail to show up for your confirmed appointment, you will be charged \$25.00.
 - 5. CHANGES IN INSURANCE:** All co-pays and fees are due in full at the time of service.
 - 6. DELINQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing costs and processing fees.
-

Patient or Responsible Party:

Signature _____ Date _____