APOS

ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS

Dr's Mc Master, Weinert, Rosenfeld, Dobyns, Aminian, Lalonde, Schlechter
1310 W. Stewart Dr. Suite 508, Orange, CA 92868 (714)633-2111 FAX (714) 633-5615
25982 Pala Dr. Suite 230, Mission Viejo, CA 92691 (949)600-8800 FAX (949) 600-8813

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 _____

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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	☐ Yes ☐ No	Pleurisy	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Cough blood	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No

Gastrointestinal:

Gallstones	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No	Stomach pain	☐ Yes ☐ No	Colitis	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No	Appetite change	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Vomit blood	☐ Yes ☐ No	Blood in stool	☐ Yes ☐ No	Black stool	☐ Yes ☐ No
Pain swallowing	☐ Yes ☐ No	Hiatal hernia	☐ Yes ☐ No		

Gynecologic:

Fibroids	☐ Yes ☐ No	Ovarian cyst	☐ Yes ☐ No	Irregular periods	☐ Yes ☐ No

Last menstrual period _____ #Pregnancies _____ Last pap smear _____

Hysterectomy? ☐ Yes ☐ No At what age _____ Do you take hormones ☐ Yes ☐ No

Genitourinary:

Kidney disease	☐ Yes ☐ No	Kidney infection	☐ Yes ☐ No	Bladder infection	☐ Yes ☐ No
Blood in urine	☐ Yes ☐ No	Wetting	☐ Yes ☐ No	Stones	☐ Yes ☐ No
Poor stream	☐ Yes ☐ No	Pain on urination	☐ Yes ☐ No	Kidney failure	☐ Yes ☐ No
Venereal disease	☐ Yes ☐ No	Explain	_____		

Skin/ breast:

Rashes	☐ Yes ☐ No	Skin color changes	☐ Yes ☐ No	Skin ulcers	☐ Yes ☐ No
Lumps	☐ Yes ☐ No	Psoriasis	☐ Yes ☐ No		
Scars	☐ Yes ☐ No	Where?	_____		

Hematologic/Lymphatic/Endocrine:

Anemia	☐ Yes ☐ No	Easy bleeding	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Thyroid disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Blood disease	☐ Yes ☐ No
Muscle weakness	☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No	Easy fractures	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Thirst	☐ Yes ☐ No	Enlarged glands	☐ Yes ☐ No

Psychological:

Depression	☐ Yes ☐ No	Mood swings	☐ Yes ☐ No	Tearfulness	☐ Yes ☐ No
Poor sleeping	☐ Yes ☐ No	Angry outbursts	☐ Yes ☐ No	Hallucinations	☐ Yes ☐ No
Tiredness	☐ Yes ☐ No	Addiction history	☐ Yes ☐ No		

Neurologic:

Seizures	☐ Yes ☐ No	Weakness	☐ Yes ☐ No	Memory loss	☐ Yes ☐ No
Incoordination	☐ Yes ☐ No	Falling	☐ Yes ☐ No	Speech slurring	☐ Yes ☐ No
Vision changes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Tremors	☐ Yes ☐ No
Tingling hands or feet	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No	TIA	☐ Yes ☐ No

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

Please explain _____

_____

Signature _____ Date _____

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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 _____

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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 _____

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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 _____

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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)