Welcome

Dear Patient and Family

Thank you for choosing me to provide your orthopedic care. My office staff, team and I will make every effort to treat you with courtesy, respect and kindness, while providing the highest level of care possible.

I truly understand the frustration of having to complete new forms each time you see another physician; however, in order to help me treat you accurately and efficiently, I would greatly appreciate it if you would take a few minutes to complete the appropriate forms as thoroughly as possible and would like to thank you in advance for doing so.

Please be sure to fill out a separate musculoskeletal questionnaire sheet for each area of the body, for which you have been scheduled for your appointment, if multiple body sites are affected.

I typically spend an ample amount of time during the first visit educating my patients and their family about their diagnosis and together determining a customized treatment plan that will best suit their needs. As a result of this philosophy, and the occasional need to fit in patients with emergency conditions, we will at times find it hard to stay on schedule. Please know that we do respect your time, and we will make every effort to see you as close to your scheduled time as possible.

We understand that schedules change and that there may be a need to cancel or re-schedule your appointment. Please give us at least 24 hours notice so that we can offer your appointment time to another patient.

I look forward to getting to know you and helping with your orthopedic problem.

Sincerely,
John A. Schlechter, DO

PEDIATRIC ORTHOPAEDIC
SPECIALISTS OF ORANGE COUNTY
POSOC

PEDIATRICIAN / PRIMARY CARE PHYSICIAN

REFERRED: YES NO

PEDIATRICIAN / PRIMARY CARE PHYSICIAN NAME: _____

ADDRESS: _____

PHONE: ( ) _____ FAX: ( ) _____

PATIENT REGISTRATION

FIRST NAME: _____ LAST NAME: _____ M.I. _____

DATE OF BIRTH: ____/____/____ GENDER: MALE FEMALE HEIGHT: _____ WEIGHT: _____

HOME ADDRESS: _____

PREFERRED PHARMACY NAME & ADDRESS: _____

PRIMARY CONTACT (PLEASE CHECK ONE):

FATHER MOTHER GUARDIAN

NAME: _____

ADDRESS: SAME AS PATIENT

_____

HOME CELL TEXT: YES NO

PHONE NUMBER: ( ) _____

EMAIL: _____

EMPLOYER: _____

LAST 4 DIGITS OF SSN: _____ DOB: _____

SECONDARYCONTACT (PLEASE CHECK ONE):

FATHER MOTHER GUARDIAN

NAME: _____

ADDRESS: SAME AS PATIENT

_____

HOME CELL TEXT: YES NO

PHONE NUMBER: ( ) _____

EMAIL: _____

EMPLOYER: _____

LAST 4 DIGITS OF SSN: _____ DOB: _____

** I AUTHORIZE THE PHYSICIANS AND STAFF OF ADULT AND PEDIATRIC ORTHOPEDIC SPECIALISTS TO LEAVE DETAILED MESSAGESAT THE PHONE NUMBER(S) LISTED ABOVE REGARDING MY CHILD'S HEALTH, APPOINTMENTS, TEST RESULTS, AND BILLING UNLESS OTHERWISE SPECIFIED HERE:

IF PARENTS ARE DIVORCED OR SEPARATED, WHAT ARE THE LEGAL CUSTODY ARRANGEMENTS FOR THIS CHILD?

PHYSICAL CUSTODY – NAME: _____ RELATIONSHIP TO PATIENT: _____

LEGAL CUSTODY: JOINT SOLE – NAME: _____

IF SOLE LEGAL CUSTODY, PLEASE PROVIDE LEGAL DOCUMENTATION TO BE SCANNED INTO PATIENT'S CHART

CAREGIVER AUTHORIZATION: The following relative(s) and/or caregiver(s) have permission to make medical decisions on behalf of my child including physical exams, x-rays, casting, in office procedures and/or any other medical care advised by the provider and staff at the time of treatment. This authorization will be effective until further written notice.

Name/Relationship to patient: _____ **Name/Relationship to patient:** _____

INSURANCE

PRIMARY INSURANCE

SUBSCRIBER: FATHER MOTHER SELF

PLAN NAME: _____

ID #: _____

SECONDARY INSURANCE

SUBSCRIBER: FATHER MOTHER SELF

PLAN NAME: _____

ID #: _____

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

I DECLARE THE INFORMATION I PROVIDED ABOVE IS CORRECT AND IF THERE ARE ANY CHANGES I WILL NOTIFY THE OFFICE IMMEDIATELY.

NAME/SIGNATURE: _____ DATE: _____

Preparing for Your Visit

1. Please read the patient welcome letter on our website which explains my philosophy of care.

2. Please complete my forms on the website:
   APOS Patient Registration Forms and the
   Dr. John Schlechter Pediatric and Adolescent Musculoskeletal Questionnaire

3. Insurance information
   Please bring your insurance card and a photo ID

4. Imaging studies
   Please bring any recent x-rays, MRI or CT scans related to your injury. Please bring a CD of the studies or the actual films, not just the Reports

5. Clothing
   - Female shoulder patients - please bring or wear a tank top, halter or sports bra

   - Hip, knee and ankle patients – please bring or wear a pair of shorts

Dr. John Schlechter
Pediatric and Adolescent
Musculoskeletal Questionnaire

Please answer each question as completely as possible; this information will help with the diagnosis & treatment of your condition. Check boxes to indicate a positive response.

Name _____ Age _____ yrs _____ mo Sex _____

Height _____ Weight _____ Date of Birth _____ School Grade _____

Referred by _____

Primary Care Physician/Pediatrician _____ Fax # _____

Dominant Hand ☐ Right ☐ Left

Body part to be examined: ☐ Right ☐ Left

☐ Shoulder ☐ Elbow ☐ Wrist/Hand

☐ Knee ☐ Ankle ☐ Hip

☐ Other _____

How and **When** did the injury occur or the symptoms begin? Date of Injury = _____

Type of Sport= _____

Did you notice any of the following at the time of injury?

☐ A "pop" ☐ tearing sensation ☐ immediate swelling

What treatment have you received for this problem?

☐ X-ray result:
☐ MRI/CT Scan result:
☐ Bone Scan result:
☐ EMG result:
☐ Medication result:
☐ Cortisone result:
☐ Physical Therapy result: location:
☐ Surgery what procedure and when:
result:

What physician is currently treating you for this condition? _____

Dr. John Schlechter
Pediatric and Adolescent
Musculoskeletal Questionnaire

Name _____

Which of the following describes your pain?

- ☐ Sharp
- ☐ Constant
- ☐ During activities
- ☐ Aching
- ☐ Intermittent
- ☐ After activities
- ☐ Burning
- ☐ Awakens me from sleep

Where is your pain located?

☐ Front ☐ Back ☐ Inner side ☐ Outer side ☐ Top

What aggravates your symptoms?

Which of the following symptoms do you currently have?

☐ Catching or popping	caused by:
☐ Grinding	caused by:
☐ Swelling	caused by:
☐ Shooting / radiating pain	from where to where:
☐ Numbness / tingling	where:
☐ Loss of motion	describe:
☐ Weakness	with the following uses:

Does it feel at times like the involved joint dislocated or "slips out"?

Does anything improve your symptoms?

Have you had prior injuries or complaints related to this area of your body?
(If yes please describe the injury and its prior treatment.)

Dr. John Schlechter
Pediatric and Adolescent
Musculoskeletal Questionnaire

Name _____

HEALTH HISTORY

This information will remain confidential and will not be released without patient authorization. Please be as complete as possible and print clearly.

Drug Allergies / Sensitivitie (Please describe the adverse reaction) _____

_____

_____

Medical Illnesses:	Yes	No	Explain all YES answers
Heart Disease / Condition	☐	☐	_____
High Blood Pressure	☐	☐	_____
Asthma	☐	☐	_____
Diabetes	☐	☐	_____
Seizures	☐	☐	_____
Bleeding Disorder / Tendency	☐	☐	_____
Sickle Cell Anemia	☐	☐	_____
Cancer	☐	☐	_____
Kidney Disease	☐	☐	_____
Mental Illness			_____
Hepatitis / Liver Disease			_____
HIV			_____

Previous Surgeries: _____

_____

Current Medications (include herbs, supplements and diet pills) _____

_____

Family History (Any medical problems in your family) _____

_____

Social History:

Do you currently smoke cigarettes?	☐ Yes	☐ No	_____ packs daily
Do you drink alcohol?	☐ Yes	☐ No	
Do you use any other drugs?	☐ Yes	☐ No	

Sports and leisure activities: _____

Signature _____ Physician _____

Thank You For Filling Out This Form

PEDIATRIC ORTHOPAEDIC
SPECIALISTS OF ORANGE COUNTY
POSOC

Dr's Weinert, Rosenfeld, Dobyns, Aminian, Lalonde, Schlechter, McMichael, Davis and Misaghi
1310 W. Stewart Dr. Suite 508, Orange, CA 92868 Tel: (714) 633-2111 Fax: (844) 387-7625 25982
Pala Dr. Suite 230, Mission Viejo, CA 92691 Tel: (949) 600-8800 Fax: (844) 374-4221
4980 Barranca Parkway, Suite 220, Irvine CA 92604

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 healthcare 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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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.

7. **I authorize** my physician to access my medication history.

Patient or Responsible Party:

Signature_____ Date_____