

South Orange County Orthopaedics, Inc.

26730 Crown Valley Pkwy. Ste 200, Mission Viejo, Ca 92691

OFFICE: 949-364-2154 • FAX: 949-364-0957

APPOINTMENT WITH DR.:

Mark S. Ishimaru, MD Michael J. Fitzpatrick, MD Kenneth Wilkens, MD Roger C. Sohn, MD

PATIENTS' INFORMATION – PLEASE PRINT

Date: ____/____/____

Legal Last Name: _____ Patient First Name: _____ MI _____

Address: _____ City, _____, CA Zip Code _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

DOB: ____/____/____ M / F (circle one) SS#: ____/____/____

Emergency Contact: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you to this office: _____

PRIMARY INSURANCE (PLEASE CIRCLE ALL THAT APPLY)

MEDICARE MEDI-CAL PPO/PRIVATE HMO WORK COMP SELF-PAY OTHER: _____

CO-PAY: \$ _____ (CO PAYMENTS ARE DUE AT THE TIME OF SERVICE)

Date of Injury: _____ Work Related: Yes / No Auto: Yes / No

MHAP REFERRING PHYSICIAN: _____
(FIRST AND LAST NAME OF REFERRING PHYSICIAN)

Insurance Name: _____ Insurance Phone: _____

Billing Address: _____

Insured Subscriber's Name: _____ DOB: ____/____/____

SS#: ____/____/____ ID#: _____ Group #: _____ Effective Date: _____

Employer: _____

Employer's Address: _____ Phone: _____

Relationship of Patient to Insured/Subscriber: Self Father Mother Child Other: _____

SECONDARY INSURANCE

Insurance Name & Billing Address: _____

Insured Subscriber: _____ DOB: ____/____/____

ID# ____/____/____ Group #: _____ Effective Date: _____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize SOUTH ORANGE COUNTY ORTHOPAEDICS, to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I authorize them to furnish information to insurance carriers concerning this illness and/or injury. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the doctor in accordance with California Insurance Code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SUBSCRIBER/INSURED SIGNATURE: _____ DATE: _____

South Orange County Orthopaedics, Inc.

26730 Crown Valley Pkwy. Ste 200 • Mission Viejo, Ca 92691

OFFICE: 949-364-2154 • FAX: 949-364-0957

• Mark S. Ishimaru, MD • Michael J. Fitzpatrick, MD • Kenneth Wilkens, MD • Roger C. Sohn, MD •

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures 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 can contact this organization at any time at the address above 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature on acknowledgement of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initials:	Reason:

PATIENT HEALTH HISTORY

Your Health History is IMPORTANT. Please answer all questions thoroughly.

Name: _____ Today's Date: _____
 Age: _____ Height: _____ Weight: _____
 Hand Dominance: Right Left Ambidexterous

Chief Complaint

Why are you seeing the doctor today? _____
 Date of Injury: _____ Date of Surgery: _____
 Pain Level of Injury (0-10 where 0=none, 10=extreme): _____
 Current problem is the result of a(n): **Check** all that apply
 Car Accident Work Accident Other: _____

Past Medical History

Diabetes High Blood Pressure Heart Disease Lung Disorders
 High Cholesterol Kidney Problems Prostate Problems Thyroid
 Anemia Arthritis Gout Liver Disease
 Psychiatric Stroke TB Hepatitis
 Seizure Bleeding Disorders Polio Multiple Sclerosis
 Eating Disorder STD's AIDS/HIV Low Blood Pressure
 Cancer Type & Current Status: _____
 Other (please describe): _____

Past Surgical History

Surgeries/Hospitalizations	Year	Complications/Outcome

Have you ever had general anesthesia? No Yes
Have you ever had any problems with anesthesia? No Yes **Please Describe:** _____

Do you have sleep apnea? No Yes

PATIENT HEALTH HISTORY

Medication	Dose	Reason For Medication	Side Effects

ALLERGIES: Please List

Are all immunizations up to date? Yes No
 If no, which immunizations are due? _____

Review of Systems

Are you currently having or have you had problems with your:

	Circle		Describe all Yes Responses:
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Irregular Heart Beat	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movement	No	Yes	_____
Bladder Problem	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackout/Fainting	No	Yes	_____
Headaches	No	Yes	_____
Breast Mass	No	Yes	_____
Psych Problems	No	Yes	_____
Fevers/Chills	No	Yes	_____
Chest Pain	No	Yes	_____
Difficulty Breathing	No	Yes	_____
Skin Issues	No	Yes	_____
Pregnant	No	Yes	_____

Social History

Occupation: _____

- Work in Home
 Employed
 Student
 Retired

Status:

- Single
 Married
 Divorced
 Separated
 Widowed

Children? No Yes # _____

Do you live alone? No Yes

PATIENT HEALTH HISTORY

Activity Level

How often do you exercise?

Daily
 Weekly
 Monthly
 Rarely
 Never

Habits

Do you have a history of substance abuse?
 No
 Yes
 What? _____

Drink Alcohol?
 No
 Daily
 1-2 x/week
 1-2 x/month
 1-2 x/year

Currently Smoking?
 No
 Yes
 _____ Packs per day for _____ years

Quit Smoking?
 This year
 >1 year
 > 5 years
 > 10 years

Previously smoked _____ packs per day for _____ years.

Have you used other tobacco products?
 No
 Yes
 What? _____

Are you exposed to tobacco in your household?
 No
 Yes

Do you drink caffeinated beverages?
 No
 1-2 x/day
 3-6 x/day
 7-10 x/day

Family History

Relation	Age	State of Health	Age of Death	Medical Conditions or Cause of Death
Father				
Mother				
Brother				
Sister				
Grandfather (Mom's)				
Grandmother (Mom's)				
Grandfather (Dad's)				
Grandmother (Dad's)				

I certify that the above information is correct to the best of my knowledge, I will not hold my Doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

Considering you are seeing a specialist, this form must be submitted to your insurance company, whether your injury was due to an accident or specific injury.

RELEASE FORM

PATIENT NAME: _____

INJURED PART(S) OF BODY: _____

DATE OF ACCIDENT/INJURY/OR ONSET OF SYMPTOMS: _____

LOCATION INJURY OCCURRED: _____

HOW IT HAPPENED: _____

RESPONSIBLE PARTY INFORMATION – (IF DIFFERENT FROM PATIENT’S HEALTH INSURANCE): EXAMPLE – PATIENT’S AUTO INSURANCE

NAME OF INSURANCE COMPANY: _____

INSURED NAME: _____ CLAIM #: _____

INSURANCE BILLING ADDRESS: _____

AGENT’S NAME: _____ COVERAGE AMOUNT: \$ _____

PHONE: _____ FAX: _____

I hereby authorize Mark S. Ishimaru, M.D., Inc. and/or and/or Michael J. Fitzpatrick, M.D., and/or Dr. Kenneth Wilkens, M.D., and/or Roger C. Sohn, MD, to release this information to my insurance company and all other information pertaining to this accident/injury/or onset of symptoms in order to process my claim(s) involving the above event. I authorize benefits payable to Mark S. Ishimaru, M.D., Inc. and/or Michael J. Fitzpatrick, M.D., and/or Dr. Kenneth Wilkens, MD., and/or Roger C. Sohn, MD from my insurance company covering the above event. I acknowledge that any balance owed will be paid in full by myself/insured upon request of such balance, either in writing or in person.

SIGNED: _____ DATE: _____

South Orange County Orthopaedics, Inc.

26730 Crown Valley Pkwy. Ste 200 • Mission Viejo, Ca 92691

OFFICE: 949-364-2154 • FAX: 949-364-0957

NO-SHOW POLICY

Effective April 2009

We value you as a patient and recognize the difficulties you face in trying to coordinate all the demands made upon your time.

As a result of high demand on our schedules, we ask that you give us a 24-hour notice if you cannot keep your appointment. This allows us to give that time to other patients with urgent needs.

Patients who miss appointments without calling at least 24 hours in advance will be charged a \$25 fee that is not covered by any insurance including Workers Compensation.

We understand when special circumstances occur. If you call us and explain those to us at your earliest opportunity, we will be happy to reschedule your appointment and the 'No Show' will not be counted against you. A third No Show may result in the dismissal from this practice. Thank you for your cooperation.

The Physicians of South Orange County Orthopaedics

I have read and understand the policy above.

Signature

Print Name

Date