Orthopaedic Specialty Institute
Medical Group of Orange County

Patient Registration

PATIENT INFORMATION (Please Print)

Name: _____ **Sex:** ☐ Male ☐ Female

Address: _____ **Date of Birth:** _____ **Age:** _____

_____ **Social Security #:** _____

City, State, Zip: _____ **Driver's License/ID #:** _____

Race: _____ **Ethnicity:** ☐ Hispanic or Latino

Language: _____ ☐ Not Hispanic or Latino

Email address: _____ ☐ Unknown / Not Reported

Marital Status: ☐ Married ☐ Single ☐ Divorced

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell ☐ Other: _____

Primary Physician: _____ **Employer:** _____

Address: _____ **Address:** _____

Phone: _____ **Phone:** _____

Date of injury or onset of symptoms: _____ **Was this an injury?** ☐ Yes ☐ No

Where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School ☐ Other: _____

Who referred you to us/How did you hear about us? _____

GUARANTOR RESPONSIBLE PARTY ☐ Patient ☐ Other: Relationship:

Name: _____ **Employer:** _____

Address: _____ **Phone:** _____

_____ **Social Security #:** _____

City, State, Zip: _____ **Date of Birth:** _____

PRIMARY INSURANCE Insured Party: ☐ Patient ☐ Guarantor ☐ Other:

Insured's Name: _____ **Social Security #:** _____

Insurance Carrier: _____ **Date of Birth:** _____

Claims Address: _____ **Insured ID/Cert #:** _____

City, State, Zip: _____ **Group #:** _____

Phone: _____

SECONDARY INSURANCE Insured Party: ☐ Patient ☐ Guarantor ☐ Other:

Insured's Name: _____ **Social Security #:** _____

Insurance Carrier: _____ **Date of Birth:** _____

Claims Address: _____ **Insured ID/Cert #:** _____

City, State, Zip: _____ **Group #:** _____

Phone: _____

EMERGENCY CONTACT

Name: _____ **Address:** _____

Relationship: _____ **Phone:** _____

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a cash patient with payment in full due at the time of service.

This agreement will remain valid from this day forward to include all future services relating to the above patient. *Rev 05/14*

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

Orthopaedic Specialty Institute
Medical Group of Orange County

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____ Sex: _____ *Height*: _____

E-mail address: _____ *Weight*: _____

Dominant Hand: ☐ left ☐ right

Which body part is involved? _____ ☐ left ☐ right ☐ both

When did it begin? _____ Rate your pain on a scale of 1 – 10, 10 being the worst: _____

Was it caused by an injury: ☐ yes ☐ no Was the injury job related? ☐ yes ☐ no

Describe the accident (if applicable): _____

_____

How did it begin? ☐ gradually ☐ suddenly Is the condition ☐ intermittent or ☐ constant?

Do you experience pain: ☐ at night ☐ at rest ☐ continuous ☐ during activity ☐ after activity

What aggravates your condition? _____

_____

What makes the condition better? _____

_____

Have you had a similar problem in the past? ☐ yes ☐ no If yes, describe: _____

_____

Have you seen another health care provider for this problem? ☐ yes ☐ no Doctor: _____

History of Present Illness: Please check all that apply.

☐ pain	☐ catching/popping/grinding	☐ weakness	☐ instability	☐ stiffness
☐ numbness	☐ decreased range of motion	☐ swelling	☐ aching	☐ burning
☐ stabbing	☐ shooting pain	☐ throbbing	☐ locking	☐ bruising

☐ other: _____

Does it feel like the involved joint dislocates or slips out of place? ☐ yes ☐ no

Is your pain located: ☐ Front ☐ Back ☐ Inside ☐ Outside ☐ Top

Previous Treatment: Check all that apply and indicate your response to treatment.

☐ **NONE**

☐ Orthotics/Insoles _____ ☐ Brace _____

☐ Muscle relaxant _____ ☐ Physical therapy _____

☐ EMG _____ ☐ Chiropractor _____

☐ Acupuncture _____ ☐ Other: _____

☐ Narcotic medication (Norco, Vicodin) _____

☐ Anti-inflammatory (NSAID) (Aleve, Ibuprofen, Advil) _____

☐ Cortisone Injection How many in the last 12 months? _____ Any relief? _____

☐ Viscosupplementation (Orthovisc, Euflexxa, Synvisc) Last injection? _____ Any relief? _____

☐ X-rays Results: _____

☐ MRI Results: _____

☐ CT scan Results: _____

What specific activities does your condition prevent you from doing? _____

Patient Name: _____

Past Medical History: Check all that apply.

☐ **NONE** ☐ Blood clots ☐ Osteoporosis ☐ Gastric Ulcer
☐ High Blood Pressure ☐ Heart Attack/Angina ☐ HIV ☐ Diabetes
☐ Stroke ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Bleeding Disorder
☐ Cancer: specify: _____

Surgical History: Check any surgeries that you have had. *Please indicate the year of surgery to the best of your knowledge.*

☐ **NONE** ☐ Appendectomy ☐ Gall Bladder ☐ Vascular Bypass…. Where? _____
☐ Heart Surgery ☐ Hysterectomy ☐ Tonsillectomy
☐ Arthroscopic Surgery: ☐ Shoulder ☐ Knee ☐ Hip ☐ Other _____
☐ Total Joint Replacement: ☐ Knee ☐ Hip ☐ Shoulder
☐ Back Surgery: specify: _____
☐ Fracture Repair: specify: _____
☐ Other: _____
If you have had any problems with anesthesia, explain: _____

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications.

☐ **NONE**

Name	Strength	Frequency	Name	Strength	Frequency

Allergies: Check all that apply.

☐ **NO KNOWN DRUG ALLERGIES** ☐ Codeine ☐ Penicillin ☐ Iodine
☐ Demerol ☐ Aspirin ☐ Codeine ☐ Sulfa
☐ Adhesive Tape ☐ Morphine ☐ Latex ☐ NSAID's
☐ Other: _____

Social History: Please check.

☐ Married ☐ Widowed ☐ Divorced ☐ Single
Do you smoke? ☐ Yes ☐ No ☐ Former Packs/Day: _____ Number of years you have smoked: ____
☐ Cigarettes ☐ Chewing ☐ Cigar ☐ Pipe ☐ Smokeless Year quit: ____
Do you drink alcohol? ☐ Yes ☐ No Drinks/Week: _____ ☐ Beer ☐ Wine ☐ Liquor
Occupation: _____

Are you currently able to work? ☐ yes ☐ no If not, when was your last day of work? _____
Sports and Recreational Activities: _____

Family History: Please check all that have significance in your family's history, not your own history.

☐ **NONE**
Father has: ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Other: _____
Mother has: ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Other: _____
Siblings have: ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Other: _____

List family history of orthopedic problems: _____

Patient Name: _____

Review of Systems: Check any illnesses you may have or have had in the past.

General:
- ☐ Fevers
- ☐ Weight loss or gain
- ☐ Difficulty sleeping
- ☐ Night sweats
- ☐ Cancer

Head-Ears-Eyes-Nose-Throat:
- ☐ Difficulty swallowing
- ☐ Difficulty breathing
- ☐ Sleep apnea
- ☐ Vision loss or change
- ☐ Hearing loss or change
- ☐ Tinnitus (ringing in ears)

Cardiac:
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Coronary artery disease
- ☐ Coronary stent/angioplasty
- ☐ Heart attack
- ☐ Mitral valve prolapse

Pulmonary:
- ☐ Asthma
- ☐ Cough
- ☐ Emphysema
- ☐ COPD
- ☐ Shortness of breath
- ☐ Pneumonia
- ☐ Tuberculosis

☐ **NONE**

Endocrine:
- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Hyperthyroid

Genitourinary:
- ☐ Bladder infections
- ☐ Urinary frequency
- ☐ Urinary retention
- ☐ Urinary incontinence
- ☐ Venereal disease
- ☐ Kidney disease

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcer disease
- ☐ GERD
- ☐ Gallstones
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diverticulitis

Hematologic:
- ☐ Bleeding disorder
- ☐ History of DVT/PE
- ☐ Blood clots

Infectious Disease:
- ☐ HIV
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Musculoskeletal:
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Ankylosing spondylitis
- ☐ Scoliosis

Neurological:
- ☐ Seizures
- ☐ Numbness or weakness
- ☐ Balance problems
- ☐ Headaches
- ☐ Migraines
- ☐ Difficulty walking
- ☐ Peripheral neuropathy
- ☐ History of stroke
- ☐ Multiple sclerosis

Skin:
- ☐ Itching/rash
- ☐ Eczema
- ☐ MRSA/Staph infection
  Date Treated: _____

Psychiatric:
- ☐ Depression
- ☐ Bipolar
- ☐ Anxiety
- ☐ Manic
- ☐ History of drug dependency
- ☐ History of alcohol dependency

Primary Care Physician: _____

Telephone #: _____ City: _____

Would you like a letter sent to your doctor? ☐ yes ☐ no

Cardiologist: _____

Telephone #: _____ City: _____

Rheumatologist: _____

Telephone #: _____ City: _____

Other: _____

Telephone #: _____ City: _____

Pharmacy: _____ **City**: _____

Telephone #: _____

Who referred you to us? _____

Orthopaedic Specialty Institute
Medical Group of Orange County

Acknowledgement of Receipt of Notice of Privacy Practices and Notices to Consumers

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices as well as Consumers Notices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices and/or Consumer updates at each appointment.

NOTICE TO CONSUMERS

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE

(916) 561-8780

WWW.PAC.CA.GOV

NOTICE TO CONSUMERS

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA

(800) 633-2322

WWW.MBC.CA.GOV

Signature: _____ Date: _____

Print Name:_____ Telephone: _____

If not signed by the patient, please indicate Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

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Orthopaedic Specialty Institute
Medical Group of Orange County

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Today's date: _____

Patient's Name: _____
DOB: _____

I authorize Orthopaedic Specialty Institute to discuss my condition and/or medical treatment with the following person(s):

Name	Phone #

I understand that OSI will not discuss my condition and/or treatment with anyone not on this list.

_____ _____
Patient signature Date signed

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