



# Orthopaedic Specialty Institute

Medical Group of Orange County

\_\_\_\_\_, your appointment with Dr. Shepard is scheduled for:

- Monday     Tuesday     Wednesday     Thursday     Friday

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

**\*\*Kindly give 24 hour notice of cancellation\*\***

**Please remember to bring:**

- ✓ Any forms sent by my office to be filled out at home
- ✓ **Insurance Cards and/or Claim Forms**
- ✓ **\*\*\*X-rays, MRI films, CT Scan, etc. relating to injury\*\*\*- otherwise appt will be rescheduled.**
- ✓ **For female shoulder patients: please bring or wear a tank, halter, or bathing suit top**
- ✓ **For hip, knee and ankle patients: please bring or wear a pair of shorts**
- ✓ **Patients with injuries to the back or neck will be evaluated in a gown**

**Orthopaedic Specialty Institute**

**Michael Shepard, M.D.**

**280 S. Main Street, Suite 200**

**Orange, CA 92868**

**(714) 937-2148**



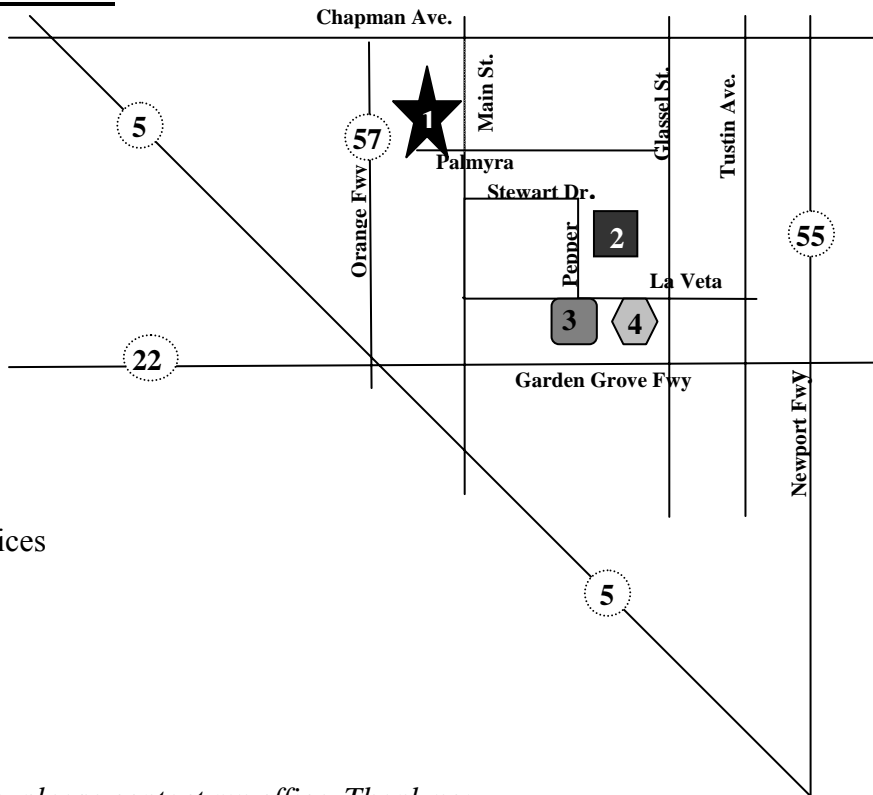
St. Joseph Hospital



St. Joseph Pavilion



Orange Surgical Services



*If you need further assistance, please contact my office. Thank you.*



# Orthopaedic Specialty Institute

## Medical Group of Orange County

### Patient Registration

Select your physician:

- |  |  |   |   |   |  |
|--|--|---|---|---|--|
| <input type="checkbox"/> Gregory D. Carlson  | <input type="checkbox"/> Jeffrey E. Deckey | <input type="checkbox"/> Robert S. Gorab  | <input type="checkbox"/> Jiun-Rong Peng   | <input type="checkbox"/> Michael F. Shepard |  |
| <input type="checkbox"/> Lawrence S. Barnett | <input type="checkbox"/> Jack Chen         | <input type="checkbox"/> Paul T. Dinh     | <input type="checkbox"/> Robert C. Grumet | <input type="checkbox"/> Carlos A. Prietto  | <input type="checkbox"/> David C. Smith    |
| <input type="checkbox"/> Steven L. Barnett   | <input type="checkbox"/> Michael I. Danto  | <input type="checkbox"/> Scott P. Fischer | <input type="checkbox"/> Mark N. Halikis  | <input type="checkbox"/> Miguel P. Prietto  | <input type="checkbox"/> Benjamin D. Rubin |

<b>PATIENT INFORMATION</b>	(Please Print)	<b>Appointment Date:</b>
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Name: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address: _____	Date of Birth: _____ Age: _____
City, State, Zip: _____	Social Security #: _____
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	Driver's License/ID #: _____
Primary Phone: _____	Email address: _____
Alternate Phone: _____	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Other: _____
Who referred you to us/How did you hear about us?	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Other: _____
Primary Physician: _____	Employer: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Date of injury or onset of symptoms: _____	Was this an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Where did your injury occur? <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Other: _____	

<b>GUARANTOR RESPONSIBLE PARTY</b>	<input type="checkbox"/> Patient <input type="checkbox"/> Other:	<b>Relationship:</b>
------------------------------------	--	----------------------

Name: _____	Employer? _____
Address: _____	Phone: _____
City, State, Zip: _____	Social Security #: _____
	Date of Birth: _____

<b>PRIMARY INSURANCE</b>	Insured Party: <input type="checkbox"/> Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Other:
--------------------------	--

Relationship to Patient: _____	Social Security #: _____
Insurance Carrier: _____	Date of Birth: _____
Claims Address: _____	Insured ID/Cert #: _____
City, State, Zip: _____	Phone: _____

<b>SECONDARY INSURANCE</b>	Insured Party: <input type="checkbox"/> Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Other: _____
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Relationship to Patient: _____	Social Security #: _____
Insurance Carrier: _____	Date of Birth: _____
Claims Address: _____	Insured ID/Cert #: _____
City, State, Zip: _____	Phone: _____

<b>EMERGENCY CONTACT</b>
--------------------------

Name: _____	Street Address: _____
Relationship: _____	City, State, Zip: _____
	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 8/09

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
DATE

**Michael F. Shepard, M.D.**  
**Orthopaedic Specialty Institute**

MEDICAL HISTORY

DATE: \_\_\_\_\_

NOTE: PLEASE TRY TO ANSWER EVERY QUESTION TO THE BEST OF YOUR ABILITY.  
EVERYTHING IS KEPT CONFIDENTIAL.

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CHIEF COMPLAINT \_\_\_\_\_  
PLEASE DESCRIBE THE RECENT EVENTS OF THIS CURRENT ORTHOPAEDIC PROBLEM. HOW LONG HAS IT BEEN A PROBLEM? WHAT MAKES IS WORSE? WHAT MAKES IT BETTER?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ONSET DATE \_\_\_\_\_

DO YOU WEAR GLASSES/CONTACTS/NONE (PLEASE CIRCLE)

NAME OF THE PHYSICIAN WHO REFERRED YOU TO US \_\_\_\_\_  
DRUG ALLERGIES \_\_\_\_\_

CURRENT MEDICATIONS: PLEASE LIST ASLL CURRENT MEDICATIONS. IF UNSURE, CALL OR MAIL ACCURATE LIST AS SOON AS POSSIBLE.

	MEDICATION	DOSE	FREQUENCY
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		

PAST SURGERIES: LIST PAST SURGERIES IN CHRONOLOGICAL ORDER:

	TYPE OF SURGERY	YEAR
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	

# Michael F. Shepard, M.D.

## Orthopaedic Specialty Institute

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** List medical illness affecting your immediate family

	Disease	Family Member	Disease	Family Member
1.	_____	_____	4.	_____
2.	_____	_____	5.	_____
3.	_____	_____	6.	_____

\_\_\_\_\_ Height                      \_\_\_\_\_ Weight

**SOCIAL HISTORY:** Check and fill in blanks

Married     Single     Divorced     Live Alone     # Children     Pets  
 Alcohol     Occasional     Daily     Heavy  
 Tobacco     Years Used     Packs per day     Drugs

**GENERAL HISTORY:** Please fill out and check all that apply.

**General**

- 1. Weight Change
- 2. Fever or Chills
- 3. Night Sweats
- 4. Urinary Frequency
- 5. Bleeding
- 6. Lumps or Masses
- 7. Dizziness or Fainting
- 8. Itching or Rash
- 9. Diabetes Mellitus
- 10. Thyroid Problem
- 11. Cancer

**Gastrointestinal**

- 1. Dysphagia (difficulty swallowing)
- 2. Nausea & Vomiting
- 3. Jaundice
- 4. Hepatitis

**Cardiovascular**

- 1. Heart dx/Pain
- 2. Hypertension
- 3. Mitral Valve Prolapse
- 4. Thrombophlebitis

**Genitourinary**

- 1. Urinary Infections
- 2. Incontinence
- 3. Venereal Disease
- 4. Menopause

**Neurological**

- 1. Seizures
- 2. Paralysis
- 3. Numbness
- 4. Weakness

**Ear-Nose-Throat-Eye**

- 1. Visual Change
- 2. Hearing Change
- 3. Tinnitus
- 4. Dentures
- 5. Bleeding Gums
- 6. Hoarseness

**Respiratory**

- 1. Cough/Sputum
- 2. Rheumatic Fever
- 3. Tuberculosis
- 4. Pleurisy/Pneumonia
- 5. Shortness of Breath
- 6. Asthma

**Musculoskeletal**

- 1. Backache
- 2. Joint Pain
- 3. Joint Swelling

**Breast**

- 1. Lumps, Pain, Nipple Discharge



# Orthopaedic Specialty Institute

Medical Group of Orange County

## Accident/Injury Information Form

Name: \_\_\_\_\_ Doctor: \_\_\_\_\_

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? \_\_\_\_\_

\_\_\_\_\_

Where did your accident/injury occur? \_\_\_\_\_

\_\_\_\_\_

How did your accident/injury occur? \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your assistance.

# Acknowledgement of Receipt of Notice of Privacy Practices

## Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. 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 at each appointment.

Signed: \_\_\_\_\_ 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: \_\_\_\_\_