ORANGE COUNTY ORTHOPAEDICS & SPORTS MEDICAL GROUP, INC.

Patient Registration Form

Today's Date: _____

Title	☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss	Marital Status	☐ Single ☐ Married ☐ Widowed		
Name		Birth Date		Gender	
Street Address		Age			
City		Social Security #			
State		Referred By			
Zip		Occupation			
Phone Number		Email address			
Employer Name					
Employer Address					

If Injury, when and how did it happen? ☐Home ☐ Work ☐ Auto ☐ Other _____

Date_____ Hour_____ Last Worked _____

Emergency Contact Name		Relationship	
Emergency Contact Phone number			
If patient is under 21 or a student			
Mother/Fathers name			
Parent occupation			
Parent Employer			
Parent Address			

Primary Insurance		**Secondary Insurance**	
Insurance Company		**Insurance Company**	
Member ID #		**Member ID #**	
Group #		**Group #**	
Insured's Name		**Insured's Name**	
Insured's Birth Date		**Insured's Birth Date**	
Insured's SS#		**Insured's SS#**	

Authorization

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees as follows: Dr Greenbaum reserves the right to designate any qualified physician to perform and administer care and treatment of the patient. Dr Greenbaum is granted permission to release to the insurance carrier, their representatives or referring physician, any information connected to any treatment rendered to the patient or on patients' behalf at any such time as information is requested. I authorize payment of medical benefits directly to Dr Greenbaum and/or Orange County Orthopaedics & Sports Medical Group, Inc. I understand that co-pays and or co-insurance is due at the time services are rendered in office. I consent to examination and treatment by Dr Greenbaum.

Patient/Parent/Legal Guardian Signature: _____ Date _____

ORANGE COUNTY ORTHOPAEDICS & SPORTS MEDICAL GROUP, INC.
PATIENT HEALTH HISTORY

PATIENT NAME: _____ TODAY'S DATE:_____

1. What is being examined today? _____Which side? (Right or left) _____

   Have you had recent x-rays/MRI taken? ⬭ YES ⬭ NO Did you bring them in today? ⬭ YES ⬭ NO

2. Date of injury or how long have you had this issue?_____

   a. WHERE injury occurred: ⬭ Home ⬭ School ⬭ Other (please specify): _____

      ⬭ Work (if so, did it occur while working for wages? ⬭ YES ⬭ NO ⬭ UNSURE

      ⬭ Motor Vehicle Accident (if so, do you have auto insurance?) ⬭ YES ⬭ NO

   b. HOW injury occurred:_____

      _____

      _____

   c. Is there a third party involved? ⬭ YES ⬭ NO

3. Have you seen a physician for this problem? ⬭ YES ⬭ NO

   a. Doctors name: _____ Address: _____

   b. Treatment (special tests, injections, medications etc.): _____

      _____

      _____

4. Have you had a previous problem in this area? ⬭ YES ⬭ NO

   a. If yes, please describe: _____

      _____

5. Have you lost time from work because of this current injury/issue? ⬭ YES ⬭ NO

   a. If yes, DATE LAST WORKED: _____

   b. Briefly describe your job activities (lifting, pushing, pulling, driving, etc.)

      _____

6. Please describe your present complaints:_____

   _____

   _____

7. Do you feel your symptoms are: ⬭ IMPROVED ⬭ MORE SEVERE ⬭ REMAINING THE SAME

PATIENT HEALTH HISTORY

PATIENT NAME: _____ TODAY'S DATE:_____

GENERAL HEALTH (Please circle one) GOOD FAIR POOR

YES____ NO ____ Have you ever been seriously ill? YES____ NO ____ Have you ever been hospitalized?

YES____ NO ____ Have you ever had surgery?

When? _____

What kind? _____

HEIGHT _____ WEIGHT _____ RIGHT/LEFT HANDED_____

HAVE YOU EVER HAD:

YES____ NO ____ CANCER

YES____ NO ____ HEART TROUBLE

YES____ NO ____ DIFFICULTY BREATHING

YES____ NO ____ LUNG DISEASE

YES____ NO ____ JAUNDICE, HEPATITIS

YES____ NO ____ DIABETES

YES____ NO ____ FAINTING SPELLS

YES____ NO ____ RHEUMATIC FEVER

YES____ NO ____ HIGH BLOOD PRESSURE

YES____ NO ____ ANEMIA OR BLEEDING ISSUES

YES____ NO ____ STOMACH ULCERS

YES____ NO ____ OTHER SERIOUS HEALTH CONDITIONS:_____

_____

YES____ NO ____ BROKEN BONES (If so which ones & when) _____

YES____ NO ____ BACK, NECK OR HEAD INJURIES? (when?) _____

DO YOU:

YES____ NO ____ TAKE MEDICATIONS REGULARLY (including oral contraceptive)

WHAT KIND?_____

_____

YES____ NO ____ SMOKE _____PKS/DAY

YES____ NO ____ DRINK ALCOHOL ⬭ DAILY ⬭ SOCIALLY ⬭ OCCASIONALLY ⬭ RARELY

YES____ NO ____ HAVE ANY ALLERGIES TO MEDICATIONS? (If yes, list medications and type of reaction; rash swelling etc.) _____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EVER HAD?

YES____ NO ____ CANCER

YES____ NO ____ HEART DISEASE

YES____ NO ____ LUNG DISEASE (TB etc.)

YES____ NO ____ DIABETES

ORANGE COUNTY ORTHOPAEDICS & SPORTS MEDICAL GROUP, INC.
Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

We are required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Orange County Orthopaedics & Sports Medical Group, Inc., and of your individual rights as well as our legal duties with respect to your confidential information.

Ways in which I may use and disclose your protected Health information:
We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating or managing your health care and related services.
- **Payment** means activities such as obtaining payment for the health care services we provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

We will use and disclose your protected health information when required by federal, state or local law. Any other uses and disclosures will be made only with your written authorization. You may be provided with an authorization form upon request. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

By signing below, you indicate you acknowledge and understand our use of your information for treatment, payment and health care operations as stated above.

I ☐ GIVE ☐ DO NOT GIVE permission for the staff of Orange County Orthopaedics & Sports Medical Group. Inc. to leave messages on my voice mail or with a designated individual (as I name below) regarding information such as: health care, medications, surgery, appointments, or billing.

Designated Individual_____ Phone number _____

Patient/Parent/Legal Guardian Signature _____

Patient Printed name_____ Date _____

ORANGE COUNTY ORTHOPAEDICS & SPORTS MEDICAL GROUP, INC.

FINANCIAL POLICIES

Thank you for choosing Orange County Orthopaedics & Sports Medical Group, Inc. the following is a statement of our financial policy. We ask that you read, agree to and sign, prior to receiving any treatment in our practice. This policy applies to all services rendered by Dr Greenbaum and his staff.

HEALTH INSURANCE

Orange County Orthopaedics & Sports Medical Group, Inc. will bill your health insurance carrier as a courtesy to you. We ask that you provide us with your insurance information and assignment of benefits at the time services are rendered. **All applicable co-pays, deductibles, and/or payment for non-covered items will be collected at the time of service**. You are 100% responsible for payment of any non-covered services. Please note that the patient is ultimately responsible for payment in full of services rendered. An anticipated insurance payment does not replace the patient obligation to pay an outstanding balance. If we do not receive payment from your insurance company in a timely manner, you will be held responsible for payment and we will be happy to provide you with any documentation needed to obtain reimbursement from your insurance company.

CASH (NON-INSURED) PATIENTS

Patients with no insurance coverage are expected to pay in full on the day services are rendered.

MANAGED CARE (HMO)

Unless an authorization is obtained from your primary care physician (PCP), you will be responsible for payment in full at the time services are rendered.

WORKER'S COMPENSATION

It is required that all Work Comp claimants have an authorization for their visit from the Workman's Compensation carrier prior to their visit. Charges for services incurred resulting from a work-related injury will be billed to your Worker's Compensation carrier. Upon any denial from said carrier, you may be held financially responsible for any outstanding balance.

RETURNED CHECKS

There will be a $25.00 fee incurred for and returned checks. All applicable discounts will be voided and patient will be responsible for payment in full for received services plus the additional $25.00 returned check fee.

Our accepted methods of payment are cash, check, Visa or MasterCard. It is ultimately the patient's responsibility to verify their benefits for their particular plan and to ensure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is obtaining care outside of their designated network or if the proper authorizations were not obtained.

Again, thank you for trusting us with your care. If you have any questions regarding your financial responsibility, please contact our insurance department.

By signing below I acknowledge that I have read, understand, and agree to the provisions of this policy.

Patient/Parent/Legal Guardian Signature_____ Date _____