WELCOME- OUR PHILOSOPHY

Dear Patient,

Thank you for choosing me to provide your orthopedic care. My 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 appreciate it if you would take a few minutes to complete the attached forms as accurately and completely as possible. Please be sure to fill out a separate history sheet for each area of the body for which you have been scheduled for your appointment.

I have found that two of the factors that create the greatest delay during office hours are the necessity for me or my physician assistant to personally complete these forms with or for the patient, and the insistence by patients that they be seen for a problem for which they are not scheduled "as long as they are here". As a result the waiting time for other patients is increased as is the level of frustration for all of us. Your cooperation will enhance your experience with my practice.

My staff and I spend a great deal of the time during the first visit educating our patients about their diagnosis and together determining a customized treatment plan that will best suit their needs. We feel that when our patients understand their own bodies and the numerous treatment options, they have more control of their problem and can be proactive in their treatment. I have found that if patients write down their questions it helps insure that they don't forget to ask for information that is important to them.

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 reschedule 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 you with your orthopedic problem.

Sincerely,

Ben Rubin, M.D.

YOUR FIRST VISIT

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

2. Please complete the forms on our website:
   OSI Patient Registration Form
   Orthopedic Questionnaire
   General Health History

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

   Neck and back patients – will be provided with examination gowns

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

SPORTS MEDICINE HEALTH QUESTIONNAIRE

Please answer each question as completely as possible.
This information will help diagnose and treat your condition

Patient Name: _____ **Today's Date:** _____

DOB:_____ **Age:** _____ **Sex:** ☐ Male ☐ Female ***Height*:** _____

Occupation: _____ ***Weight*:** _____

Who referred you to see me today?_____ ***Dominant Hand:*** ☐ **right** ☐ **left**

Body part to be examined: ☐ Right ☐ Left
☐ Shoulder ☐ Knee ☐ Elbow ☐ Hip ☐ Other _____

How and when did the injury occur or the symptoms begin?

At the onset of this problem did you notice any of the following?
☐ A "pop" ☐ Tearing sensation ☐ Immediate swelling

Has anyone previously treated you for this condition? _____

If so, when? _____

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

☐ NONE
☐ X-rays Results:_____
☐ MRI Results:_____
☐ CT scan Results:_____
☐ EMG _____ ☐ Physical therapy _____
☐ Chiropractor _____ ☐ Acupuncture_____
☐ Cortisone Injection How many in the last 12 months? _____ Any relief? _____
☐ Viscosupplementation (Orthovisc, Euflexxa, Synvisc) Last injection? _____Any relief? _____
☐ Medication: ☐ Anti inflammatories_____ ☐ Pain medications _____ ☐ Other _____
☐ Brace _____ ☐ Orthotics/Insoles_____
☐ Other: _____

Patient Name: _____

Current Symptoms: Please check all that apply.

Do you currently have any of the following complaints?

☐ Catching/popping/locking ☐ Grinding ☐ Swelling ☐ Weakness
☐ Instability ☐ Numbness / tingling ☐ Loss of motion

Which of the following describes your pain?

☐ Sharp/Stabbing ☐ Aching ☐ Burning ☐ Throbbing
☐ Constant ☐ Intermittent ☐ Awakens me from sleep _____ nights per week
☐ During activities ☐ After activities

Where is your pain located?

☐ Front ☐ Back ☐ Inside ☐ Outside ☐ Top

What activities aggravate your condition?

What makes your condition feel better?

Have you had any prior injuries to this area of your body? *(If yes, please describe the injury and its prior treatment)*

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: _____

Patient Name: _____

Past Medical History: Have you ever had any of the following? Check all that apply and specify as indicated.

General:
☐ Cancer _____

Head-Ears-Eyes-Nose-Throat:
☐ Sleep apnea

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

Pulmonary:
☐ Asthma
☐ Emphysema
☐ COPD
☐ Pneumonia
☐ Tuberculosis

Endocrine:
☐ Diabetes
☐ Hypothyroid
☐ Hyperthyroid

Genitourinary:
☐ Bladder infections
☐ Venereal disease
☐ Kidney disease

Gastrointestinal:
☐ Ulcer disease
☐ GERD
☐ Gallstones
☐ Diverticulitis

Skin:
☐ Eczema
☐ MRSA/Staph infection
Date Treated: _____

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

Neurological:
☐ Seizures
☐ Balance problems
☐ Headaches
☐ Migraines
☐ Peripheral neuropathy
☐ History of stroke
☐ Multiple sclerosis

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

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

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

☐ **NONE**
☐ Other _____

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 or Drug Reactions: Check all that apply.

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

Social History: Please mark every area.

Tobacco use: ☐ Yes ☐ No ☐ Former ☐ Cigarettes ☐ Cigar ☐ Chewing ☐ Pipe ☐ Smokeless
Cigarettes: Pack(s) per day: _____ How many years: _____ If you quit, when? _____
Other tobacco use: Amount per day: _____ How many years: _____ If you quit, when? _____
Alcohol use: ☐ Yes ☐ No If yes, how many drinks per week? _____
Are you currently able to work? ☐ Yes ☐ No If not, when was your last day of work? _____
Sports and Recreational Activities: _____
_____

Patient Name: _____

Review of Systems: Check any illnesses you currently have.

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

Pulmonary:
- ☐ Shortness of breath
- ☐ Cough

☐ **NONE**

Genitourinary:
- ☐ Urinary frequency
- ☐ Urinary retention
- ☐ Urinary incontinence

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting

Cardiac:
- ☐ Chest pain

Neurological:
- ☐ Numbness or weakness
- ☐ Difficulty walking

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

Family History: Has anyone in your family had any of the following problems?

☐ No significant past family history ☐ Unknown family history

Disease	Mother	Father	Brothers	Sisters	Daughters	Sons
High blood pressure/hypertension						
Heart attack/Heart surgery						
Diabetes						
Stroke						
Cancer (type)						
Arthritis						
Other (please specify)						

Primary Care Physician: _____

Telephone #:_____ City: _____

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

Cardiologist: _____

Telephone #:_____ City: _____

***Please provide your pharmacy information. This will allow us to send medications to your pharmacy. ***

Pharmacy:_____

Address: _____

City: _____

Telephone #: _____