FallbrookTemeculaValley
orthopaedic associates

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
NAME	SSN#	BIRTHDATE	SEX : MALE ☐ FEMALE ☐
PRIMARY ADDRESS		EMERGENCY CONTACT NAME	
CITY, STATE, ZIP		BIRTHDATE	Relationship to Patient
		PHONE	☐ HOME ☐ CELL ☐ OTHER
PHONE ☐ HOME ☐ CELL ☐ OTHER		OCCUPATION	
PHONE ☐ HOME ☐ CELL ☐ OTHER			
MARITAL STATUS ☐Married ☐Single ☐Divorced ☐Widowed			
PRIMARY CARE PHYSICIAN			

RESPONSIBLE PARTY / SUBSCRIBER INFORMATION (If different than above)			
NAME	SSN#	BIRTHDATE	SEX: MALE ☐ FEMALE ☐
PRIMARY ADDRESS			
CITY, STATE, ZIP			
PHONE			

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY #	
NAME OF PRIMARY INSURED MEMBER	DATE OF BIRTH	GROUP #	
ADDRESS OF INSURANCE COMPANY		CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If applicable)			
NAME OF INSURANCE COMPANY		POLICY #	
NAME OF PRIMARY INSURED MEMBER	DATE OF BIRTH	GROUP #	
ADDRESS OF INSURANCE COMPANY		CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

I hereby assign the insurance benefits to which I am entitled, directly to Fallbrook-Temecula Valley Orthopaedic Associates. 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. I hereby authorize treatment by Fallbrook-Temecula Valley Orthopaedic Associates. A Photostat of this authorization is accepted with the same authority as original.

_____ _____

SIGNATURE OF PATIENT / GUARDIAN DATE

This agreement will remain valid from this day forward to include all future services relating to the above patient, or until changes in the above information are required. It is the patient's responsibility to notify FTVOA of any changes in information.

PATIENT INFORMATION AND MEDICAL HISTORY

Name: _____ Date of Birth: _____Height:_____Weight: _____

HISTORY & PRESENT ILLNESS

What are you seeing the Doctor for? (Please be specific): _____

_____

Date of Injury: _____How long have you had these symptoms?_____

_____

PAST MEDICAL HISTORY

All Previous Medical Problems and Hospitalizations:

Yes __ No __ Childhood Diseases Circle: (measles | mumps | chicken pox | etc.)
When_____ | _____ | _____ | _____
If "etc." please elaborate_____

Yes __ No __ Rheumatic Fever When_____
Yes __ No __ Allergies, hives or drug reactions When_____
Yes __ No __ Asthma When_____
Yes __ No __ Diabetes When_____
Yes __ No __ Thyroid Problems When_____
Yes __ No __ Bronchitis When_____
Yes __ No __ Emphysema When_____
Yes __ No __ Stroke When_____
Yes __ No __ Heart Attack When_____
Yes __ No __ High Blood Pressure When_____
Yes __ No __ Murmurs When_____
Yes __ No __ Ulcers When_____
Yes __ No __ Migraines When_____
Yes __ No __ Sexually transmitted diseases When_____
Yes __ No __ Cancer When_____

OTHER PROBLEMS (not listed above)

_____ _____ _____ _____ _____

PAST SURGICAL HISTORY

Have you had any previous surgeries?

Procedures:	Date:	Name of Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any Previous Fractures?
When_____ Type of Fracture _____
Do you use a Walker, Cane, or Brace, if so which one? _____

_____ _____ _____
Print Name (or Legal Guardian) **Signature** **Date**

Read and Reviewed: _____ _____
(***Physician Signature)*** **Date**

PATIENT INFORMATION AND MEDICAL HISTORY

MEDICATION

What Medications are you **currently** taking?

Name:	***Doses:***	***Times/Day:***	***Reason:***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you Allergic to **ANY** Medications? If so What?

_____

_____

_____

SOCIAL HISTORY

Have you ever smoked? ____ How many packs a day? _____ How many years? _____

Do You Drink Alcoholic Beverages? _____ How Often? _____

Have You Lost Weight Recently? _____

Have You Had Faintness, Numbness, and Convulsions? _____

Do You Use Drugs? (Marijuana, LSD, Heroin, Cocaine) _____

Do You Live Alone or with Family? _____

Do You Drive? _____

Occupational Duties: _____

FAMILY HISTORY

(PLEASE CHECK)

___ Frequently Broken Bones	Family Member_____
___ Diabetes	Family Member_____
___ Heart Disease	Family Member_____
___ Heart Attack	Family Member_____
___ Asthma	Family Member_____
___ Cancer	Family Member_____
___ Ulcer	Family Member_____
___ High Blood Pressure	Family Member_____
___ AIDS / HIV	Family Member_____
___ Hepatitis	Family Member_____
___ Kidney / Bladder	Family Member_____
___ Kidney / Stones	Family Member_____
___ Blood in Urine	Family Member_____

_____ _____ _____

Print Name (or Legal Guardian) **Signature** **Date**

Read and Reviewed: _____ _____

(***Physician Signature)*** **Date**

PATIENT INFORMATION AND MEDICAL HISTORY

REVIEW OF SYSTEMS

Have you ever, or still have problems with any of the following?

HEAD / NECK	EXPLAIN
Yes ___ No ___ Headaches, dizziness	_____
Yes ___ No ___ Eye (glaucoma, vision changes)	_____
Yes ___ No ___ Ear (hearing, earaches, discharge)	_____
Yes ___ No ___ Nose (sinus, bleeding, obstruction)	_____
Yes ___ No ___ Mouth (pain, bleeding, sores)	_____
Yes ___ No ___ Throat (tonsillitis, hoarseness)	_____
ENDOCRINE	
Yes ___ No ___ Heat or cold intolerance	_____
Yes ___ No ___ Nervousness, sluggishness	_____
Yes ___ No ___ Hair changes, breast nodules	_____
RESPIRATORY	
Yes ___ No ___ Chest pain, shortness of breath	_____
Yes ___ No ___ Cough, sputum, night sweats	_____
CARDIAC	
Yes ___ No ___ Edema, chest pain or pressure	_____
Yes ___ No ___ Difficulty Breathing (day or night)	_____
Yes ___ No ___ Blue fingers or toes	_____
HEMATOLOGIC	
Yes ___ No ___ Tendency to bruise or bleed	_____
Yes ___ No ___ Anemia, lumps or bumps	_____
GASTROINTESTINAL	
Yes ___ No ___ Heartburn, lots of gas or belching	_____
Yes ___ No ___ Nausea and vomiting, diarrhea	_____
Yes ___ No ___ Hernia, dark urine, yellow skin	_____
Yes ___ No ___ Hemorrhoids, stool changes	_____
Yes ___ No ___ Bladder or bowel changes	_____
NEUROMUSCULAR	
Yes ___ No ___ Seizures, dizziness room spinning	_____
Yes ___ No ___ Tremors, nerve pain	_____
Yes ___ No ___ Paralysis, numbness or tingling	_____
Yes ___ No ___ Fatigue or insomnia	_____
Yes ___ No ___ Stiffness, deformity, cramps	_____
GENERAL	
Yes ___ No ___ Skin rashes, itching, color changes	_____
Yes ___ No ___ Alteration in hair or nails	_____
Yes ___ No ___ Any other symptoms or problem	_____

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____

Print Name (or Legal Guardian) **Signature** **Date**

Read and Reviewed: _____ _____

(***Physician Signature)*** **Date**

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____

DOB: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" (PHI) under a federal health privacy law, as indicated or described below:

☐ All health information relating to me.
☐ NO information, other than that required or allowed by law.
☐ ONLY the following specified information. (Describe specific information including dates of service).

Please list the individual(s) or organization(s) to whom the disclosure may be made:

Name:	**Relationship:**	**Phone Number:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand in making this request that:

- If the individual(s) or organization(s) that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

- I may revoke this authorization at any time by notifying you in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by you before receiving my revocation.

This authorization expires one year from the date signed, as indicated below, or until revoked by me in writing.

_____	_____	_____
Print Name (or Legal Guardian)	**Signature**	**Date**

If signed by the patient's personal representative the personal representative hereby states and represents they have been appointed, or have received authorization, to act as the patient's personal representative.

_____	_____
Witnessed by	**Date**

PRIVACY NOTICE

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Effective April 14, 2003, revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use and disclosure of patient health information. The following summarizes the new law and under what circumstances it may be disclosed.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment, payment, and health care operation purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide for you, providing your PHI to your insurance company for reimbursement, to remind you of appointments, and as part of our quality improvement program. We are also permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives, or a close personal friend when the information we disclose is relevant to the individual's involvement with your care, or is required to assist in your health care (e.g., pick-up prescriptions, other documents, or note follow-up care instructions, etc.). We will disclose your PHI when we refer you to other physicians or providers of health care. Finally, we reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI and to request portions of your PHI be amended. However, our practice is not obligated to agree to requested restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive a copy of your PHI, but you must pay a reasonable charge for the labor and costs associated with copying your PHI. Finally, you have a right to receive an accounting of disclosures of your health information.

Authorization for Other Uses

Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke authorization at any time by notifying us in writing that you wish to revoke your authorization.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting the Director of Business Operations, at Fallbrook-Temecula Valley Orthopaedic Associates, Fallbrook Office (760) 2728-5851 or Murrieta Office (951) 698-4660, or the Secretary of Health and Human Services. No individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I have received this summary and a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

_____	_____	_____
Print Name (or Legal Guardian)	**Signature**	**Date**

FINANCIAL POLICY

Thank you for choosing Fallbrook-Temecula Valley Orthopaedic Associates as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check, debit or credit cards.

Regarding Insurance
We participate in multiple insurance plans. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies.

Past Due Accounts
Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

Co-Pays
Payment for co-pays is expected at time of service.

Returned Checks
For checks returned to us as unpaid by your bank, we will charge a $25.00 fee.

I have read the Financial Policy. I understand and agree to the Financial Policy.

_____	_____	_____
Print Name (or Legal Guardian)	**Signature**	**Date**