LA VETA ORTHOPAEDIC ASSOCIATES REGISTRATION FORM

The information on this form is kept confidential and will be part of your medical record.

TODAY'S DATE: YOUR PRIMARY CARE PHYSICIAN:

PATIENT INFORMATION (Please fill out completely. This information is used to assist us in processing your claim.)

Patient's Last Name	First	Middle	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss	Sex ☐ M ☐ F ☐ Sgl ☐ Mar ☐ Div ☐ Sep ☐ Wid

Street Address	City	State	ZIP Code	Birth Date	Age

Social Security #	Home Phone No. (can we leave test results on your answering machine ☐ Yes ☐ No	Cellular Phone #	E-Mail Address
	( )	( )	

Occupation	Employer	School or College attending and Grade level

Who REFERRED you: ☐ Dr. __________ ☐ Hospital ER ☐ Insurance Co. ☐ St Joseph Hosp Referral

☐ Family/Friend: who? ☐ Web/Internet Site: Which One?(Google; Yelp; Facebook)

Other FAMILY MEMBERS Seen in our Office

Is the problem you are here for part of a Third Party Case (car accident)? ☐ No ☐ Yes

Third Party: In the case of a litigated personal injury or any car accident injury your medical insurance cannot be billed and your charges today will have to be paid in full. Ask for the Third Party Policy form.

Were you injured on the job (Work Comp)? ☐ Yes ☐ No

What was the date of your injury? (used for insurance billing) or ☐ No Specific Injury Date

What specific body part(s) are you being seen for today?

HEALTH INSURANCE (PLEASE GIVE YOUR INS. CARD AND ID TO THE RECEPTIONIST TO COPY)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No.
Is this person a patient here?	☐ Yes ☐ No		( )

Occupation	Employer	Employer Address	Employer Phone No.
			( )

Please indicate your primary insurance:

Subscriber's Name	Subscriber's Social Security #	Birth Date	Group #	Policy #	Co-Pay
					$

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

IMPORTANT: IN CASE OF EMERGENCY WHO CAN WE CONTACT FOR YOU (Please list 2 contacts)

Name of Friend or Relative	Relationship to Patient	Home Phone No.	Work/Cell Phone No.	Is it OK for us to discuss your medical information with them?
		( )	( )	☐ Yes ☐ No
		( )	( )	☐ Yes ☐ No

FINANCIAL AGREEMENT/ASSIGNMENT AND RELEASE

I hereby authorize and consent to the examination and treatment as deemed necessary by my physician at "La Veta Orthopaedic Associates". I have read the Financial Agreement on the other side of this form and I agree to be bound by its terms. I understand and agree that I am ultimately responsible for the balance on my account for any professional services or equipment rendered. I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party, insurance company, Third Party payer, or because of pending legal claims. I certify that the above information is true to the best of my knowledge.

I hereby authorize my insurance company, including Medicare, Private Insurance or other health plans to pay directly to my physician at "La Veta Orthopaedic Associates" all benefits I am entitled to accruing under my policy. I authorize my physician or insurance company to release any information required to process my claim and secure payment.

X ______________________________

PATIENT OR GUARDIAN SIGNATURE DATE

(TURN OVER FOR OUR FINANCIAL POLICY)

LA VETA ORTHOPAEDIC ASSOCIATES FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our practice is committed to providing the best treatment for our patients. In order to achieve these goals, we need your assistance and your understanding of our financial policy

General: We accept Visa, Mastercard, Cash, and Checks. We accept many employer group plans, Medicare, (PPO) Preferred Provider Organizations, and (WC) Workers Compensation Insurance. We do NOT accept HMO insurance. You should be aware of any out-of-pocket expenses which you may incur when seeking medical care. Payment for services is due at the time service are rendered unless payment arrangements have been arranged in advance.

Usual, Customary and Reasonable Fees: The 'UCR' is defined as usual, customary, and reasonable fees for this region. Our fees fall within the acceptable range as determined by the Orange County Medical Association and by most companies and therefore are covered up to the maximum allowance determined by each carrier. Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees that they will pass as "UCR" and does not reflect current cost of care in this area.

Insurance Billing and Payments: Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Filing insurance claims is a courtesy service that we extend to our patients. Not all services and medical equipment will be covered. In the event your insurance company has not paid your account in full within a reasonable period, the balance will be transferred to you. **You are ultimately responsible for your bill.**

In-Network and Out-of-Network Providers: For those plans that we are in-network "providers," we have agreed to provide a discount on our UCR fees. If we were not "providers" or if your insurance plan changes to one for which we are not "providers" all charges for your care will be due at the time for service. You will need to submit the receipts to your insurance for reimbursement.

Medicare: Medicare pays 80% of their allowed amount. You are responsible 20% of Medicare's allowed amount and your yearly deductible. It is illegal for us not to charge the 20%. You will be billed in full for those services and supplies that Medicare does not cover. We will bill your secondary insurance as a courtesy. Patients, who switch from the traditional Medicare coverage to a Medicare HMO, must inform us prior to receiving medical care and will be responsible for all charges. Should Medicare deny medical claims due to a patient's enrollment in an HMO, the patient will be responsible for full payment of services rendered.

Returned Checks: A $25.00 fee plus any bank charges will be charged for any returned check.

Motor Vehicle and Personal Injuries (third Party Claims): We do not file Third Party Liability Claims for motor Vehicle injuries or injuries sustained through fault of another party. Patients are expected to pay for services rendered at the time of service. They will be provided billing documents which can be presented to their attorney or Third Party Liability Carrier. We do not accept liens.

By signing the form on the opposite side of this page you are acknowledging this financial agreement and also agree to be bound by its terms.

La Veta Orthopaedic Associates
Christopher A. Wills, M.D., Paul A. Beck, M.D.,
Steve A. Mora, M.D., Michael J. Gillman M.D.
725 West La Veta, Suite 260, Orange, CA 92868
Office 714.639.3750, Fax 714.771.5194
www.MyOrthoDoc.com

ORTHOPAEDIC SURGERY WORK COMP/MED LEGAL INITIAL EVALUATION

Please answer these questions regarding your injury. Please be specific and complete all questions. If at anytime you need more space, use the back of these sheets. This form will be part of your permanent medical record.

DATE THIS FORM FILLED OUT:__________200__

NAME: Last________________________________M.I._______First____________________________

HOME ADDRESS:____CITY__________________ZIP__________

TELEPHONES: HOME ( ) ___________________________ WORK ( ) _________________________

CELLULAR ( ) _______________________

DATE OF BIRTH: __________________AGE: ______________ S.S.N. _______-________-_________

GENDER (CIRCLE): MALE FEMALE

WHAT HAND DO YOU WRITE WITH? (CIRCLE): RIGHT LEFT

OCCUPATION OR JOB TITLE: _______________________________

HEIGHT_________WEIGHT___________

FAMILY DOCTOR OR INTERNIST____

HISTORY OF PRESENT ILLNESS (Please answer all questions)

Did your Injury occur at work? Yes/No Was it due to a SINGLE injury or due to a GRADUAL problem?

Date of injury__________________________Date first reported______________To whom?__________________

What part (s) of the body were injured (be specific)? 1)_________________________2)______________________

3)___________________________4)____________________________5)________________________________

____

Who was your employer at the time? ____

What was your occupation or Job title at that time? _______________________________

How did the injury,incident or accident happen? ____

____

____

____

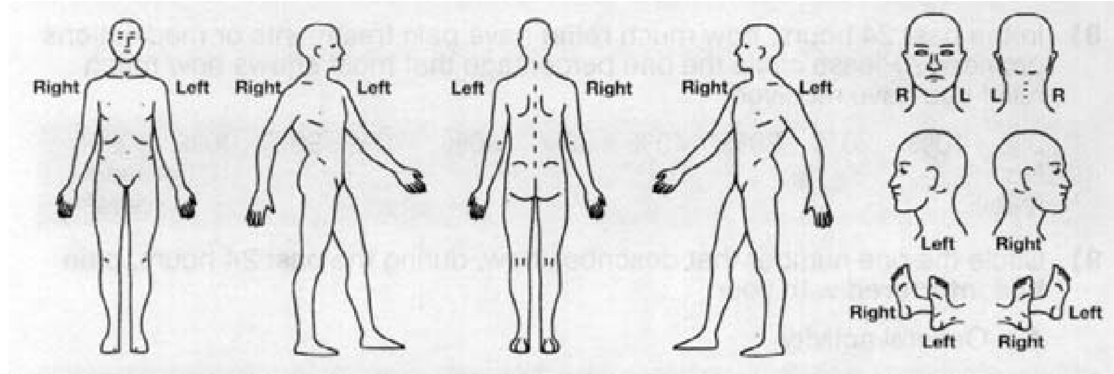
Did you finish your shift? YES/NO When did you report it?________________

Have you RE-INJURED yourself since the first injury? YES/NO
Explain____

____

Have you ever seen another doctor, chiropractor or other medical provider for treatment of these injured body parts? Yes or No____

PRESENT COMPLAINTS (Please answer all questions)
Mark on the diagram the body parts that are painful with an X



Grade the SEVERITY of your pain. Use the scale from 1(very mild) through 10(excruciating):

What is your pain now: grade_______ WORSE pain gets: grade______ BEST pain gets: grade________

What makes it WORSE:____

What makes it BETTER:_____________________________________

Describe the pain:_____________________________________ Does it hurt at rest? YES/NO

Pain Frequency: Constant or Intermittent What Percentage (%) of the day do you have pain?_____________

What other symptoms do you experience other than pain:____________________________________

Grinding or clicking? YES/NO Locking? YES/NO Giving-way? YES/NO Weakness ? YES/NO

Are your symptoms different today then they were at the initial onset?____________________________________

What are you no longer able to do at WORK because of this injury?________________________________

What are you not able to do at HOME (sports, daily activities)?____
____

TREATMENT TO DATE OF THIS INJURY

Name of the FIRST doctor or clinic seen if known?_________________________Date seen: ____________

Name of clinic or hospital_________________ Who referred you there? Work? or Other: ____________________

What TESTS were initially done? (mark with "x") X-rays ____CT Scan _____MRI _____

Nerve Study (EMG/NCS) _____Blood tests_____Bone Scan______ Other Studies_________________

What were you initially told was wrong? ____

What treatment was initially suggested? Taken off work: YES/NO Given modified duty: YES/NO
Brace/Splint: YES/NO Steroid Injection _______ Cast__________
Medications given____
Physical Therapy YES/NO How Many weeks___________Where?_____________________________
Where you hospitalized (where?)__________________________ Dates in hospital________________

Did you have Surgery (What type?)____

Did you have follow-up visits with this same doctor or clinic?____

What else was done for the injury so far?____

List below OTHER doctors or medical professionals that you have seen for this injury,

1. Name and specialty ____Date seen ___________

   What did they do for you? ____

If you need more space to list doctors and treatments use the other side of this page to continue

WORK STATUS SINCE THIS INJURY (Please answer all questions)

When did you return to work? _____________Lost # of days______ Date last worked:___________

Same employer? YES/NO Same position? YES/NO PART or FULL Time

Work Restrictions? YES/NO Specify:____

____

Do you have a new employer since injured? Yes/No, Name____________________________________

What specific duties can you not carry out because of your injury?_________________________________

Have you been working a second job? _______explain____

YOUR PAST MEDICAL HISTORY

Do you have? (circle): Diabetes (insulin or no insulin) Heart Disease Angina Hepatitis HIV Bleeding problems Lung disease Cancer TB High blood Pressure Rheumatoid Arthritis Lupus Kidney disease Depression Bipolar disorder Peptic ulcer disease Gastritis Prostate dz Osteoporosis List others:

YOUR Medical Condition	YOUR Medical Condition

LIST YOUR OTHER PAST INJURIES OR ACCIDENTS

Injured body part	Date	Work related	Treatment	Status
		Yes or No		
		Yes or No		
		Yes or No		
		Yes or No		
		Yes or No		

PAST SURGERIES

Surgery	Date

MEDICATIONS

List Your Medications	

DO YOU HAVE ALLERGIES TO MEDICINE? YES/NO, To what?______________________________

SOCIAL HISTORY AND HOBBIES

Do you smoke now? Yes/ No Did you Quit?(when)________ # cigs per day? ______How many years? ____

Do you drink alcohol? Yes/ No How much and type? Daily________Weekly________Monthly_________

Are you under treatment or have been under treatment for: Drug addiction YES/NO Alcohol addiction YES/NO

Marital Status (circle): Married Single Separated Divorced Widowed # of Children_______

Hobbies/Interests (circle): Gardening Fishing Playing Instrument Golf Bowling Skiing Hunting Tennis Cycling Hiking Reading Handiwork Mechanics Flying Time with family Other:____________________

SYSTEM REVIEW

Are you experiencing or have ever had any of the following (circle): Shortness of Breath, dizziness, chest pain, passing out, multiple joint pain, urinating problems, stomach pain, infections, current fevers, menstrual problems, psychiatric problems, liver disease, HIV, Hepatitis B or C, previous heart disease or attacks, strokes, taken blood thinners

OCCUPATIONAL HISTORY

Employer at the time of Injury ___________________________________Job title:__________________________

Is this your current employer?_______________

How long had you been working there when you became injured?_____years ____months ______days

Describe usual duties:____

Do you have to lift? Yes/ No Explain____

Do you have to reach overhead? Yes/ No Explain____

Do you use a keyboard or mouse? Yes/ No Hours/day______________

Do you have to kneel, squat, bend down Yes/ No Explain____

Do you currently have second job part or full time? Yes No Explain_____________________________

OTHER EMPLOYERS

In chronological (most recent to oldest) order:

Previous employer ____ Occupation ________________________

From ________________________________ To ____

Previous employer ____ Occupation ________________________

From ________________________________ To ____

SIGNATURES

The information I provided above is accurate to the best of my recollection

Patient's Signature (or parent if patient is a minor) _____________________________________Date ___________

Interpreter Signature (If applicable) ____Date __________

Acknowledgement of Receipt of Notice of Privacy Practices

LA VETA ORTHOPAEDIC SURGERY ASSOCIATES

725 W. La Veta Ave. Ste. 260 Orange, CA 92868

Privacy Officer – Paul A. Beck MD 714.639.3750

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices to review. I further acknowledge that a copy of the current notice will be posted in the reception area and on this practice's web site (www.MyOrthoDoc.com). I will be offered a copy of any amended Notice of Privacy Practices to review at each appointment.

Print Name: ____________________________ Telephone: ______________________

Signed: ________________________________ Date: __________________________

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: ____

©2002 by PrivaPlan Associates, Inc and the California Medical Association
Patent Pending-All rights Reserved.
9-30-02