PATIENT INFORMATION

Home Phone _____

Business Phone _____

Date _____ E-mail _____ Mobile # _____

Patient _____ SS # _____
Last Name First Name M.I.

Sex ☐ M ☐ F Age _____ Birthdate _____ Driver's Lic. # _____

Street Address _____

City _____ State _____ Zip _____

Patient Employed By _____ Occupation _____

Business Address _____

Primary Care Doctor _____ City _____ Phone _____

Who referred you to our practice? _____

Do you have Medical Insurance? No Yes If yes, name of subscriber: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Primary Language _____ Race _____

Spouse's Name _____ Birthdate _____ SS # _____

Spouse's Employer _____ Work Phone _____

Is the patient a minor, student, or insured under parent? No Yes

If yes, please provide the following:

Mother's Name _____ Birthdate _____ SS # _____

Street Address _____ Home Phone _____

Mother's Employer _____ Work Phone _____

Father's Name _____ Birthdate _____ SS # _____

Street Address _____ Home Phone _____

Father's Employer _____ Work Phone _____

Emergency Contact: _____ Phone _____

AUTHORIZATION TO PAY PHYSICIAN/ ASSIGNMENT OF BENEFITS

I, the undersigned, have insurance coverage with _____ Insurance Company(ies) and assign directly to Center for Orthopaedic Specialists all medical and surgical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment benefits. I authorize use of this signature on all my insurance submissions.

Signature: _____ Date: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Center for Orthopaedic Specialists for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ Date: _____
Beneficiary Signature

HEALTH QUESTIONNAIRE

DATE COMPLETED: _____

NAME _____ MARITAL STATUS: S / M / D / W AGE _____ SEX: M / F

EMPLOYER _____ OCCUPATION _____

HEIGHT _____ WEIGHT _____ BIRTHDATE _____ DOMINANT HAND: L / R

NAME OF YOUR PRIMARY CARE PHYSICIAN (INTERNIST OR PEDIATRICIAN): _____
SPORTS & HOBBIES: _____
DRUG ALLERGIES: ☐ **NONE** OR LIST: _____

CURRENT MEDICATIONS: ☐ **NONE** OR LIST: (you may use the reverse side for space): _____
TOBACCO: ☐ NONE ☐ NEVER SMOKED ☐ FORMER SMOKER ☐ CURRENT SMOKER ☐ YES, # OF PACKS PER DAY _____
ALCOHOL: ☐ NONE ☐ RECOVERING ALCOHOLIC ☐ YES, #OF DRINKS PER WEEK _____
SUBSTANCE/DRUG ABUSE: ☐ YES ☐ NO ☐ PRIOR HISTORY
PAST SURGERIES / ILLNESSES /ACCIDENTS AND HOSPITALIZATIONS: ☐ NONE – OR LIST HERE:

_____
_____
_____
_____
_____

FAMILY HISTORY: IF ANY OF THE FOLLOWING HAVE RUN IN YOUR FAMILY, PLEASE CHECK:
FATHER: AGE ____ LIVING / DECEASED ☐ ALLERGIES ☐ CANCER ☐ TUBERCULOSIS ☐ DIABETES ☐ HEART DISEASE ☐ STROKE
MOTHER: AGE ____ LIVING / DECEASED ☐ ALLERGIES ☐ CANCER ☐ TUBERCULOSIS ☐ DIABETES ☐ HEART DISEASE ☐ STROKE

SYSTEM REVIEW: PLEASE CHECK IF YOU HAVE/HAD ANY OF THESE CONDITIONS:

GENERAL: ☐ **HEALTHY** ☐ ILL RECENT WEIGHT GAIN ____ LBS., LOSS ____ LBS.
☐ PREGNANT

HEART/CIRCULATION: ☐ **NORMAL** ☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK
☐ HEART FAILURE ☐ ANGINA ☐ ARRHYTHMIA ☐ POOR CIRCULATION

LUNGS: ☐ **NORMAL** ☐ ASTHMA ☐ CHRONIC LUNG DISEASE
☐ BLOOD CLOTS IN LUNG ☐ PNEUMONIA

GASTROINTESTINAL: ☐ **NORMAL** ☐ REFLUX ☐ PEPTIC ULCER ☐ LIVER DISEASE

URINARY TRACT: ☐ **NORMAL** ☐ BLADDER INFECTION ☐ PROSTATE ENLARGEMENT
☐ FREQUENT URINATION ☐ KIDNEY STONES ☐ KIDNEY FAILURE

ENDOCRINE: ☐ **NORMAL** ☐ DIABETES ☐ THYROID ABNORMALITY ☐ OTHER

HEMATOLOGIC: ☐ **NORMAL** ☐ BLOOD CLOTS ☐ TRANSFUSION – (☐ YOUR OWN BLOOD, OR
☐ DONOR BLOOD) ☐ ABNORMAL BLEEDING TENDENCIES

NEUROLOGIC: ☐ **NORMAL** ☐ STROKE ☐ SEIZURES ☐ M.S. ☐ DEPRESSION

MUSCLES & JOINTS: ☐ **NORMAL** ☐ OSTEOARTHRITIS ☐ RHEUMATOID ☐ FIBROMYALGIA
☐ GOUT

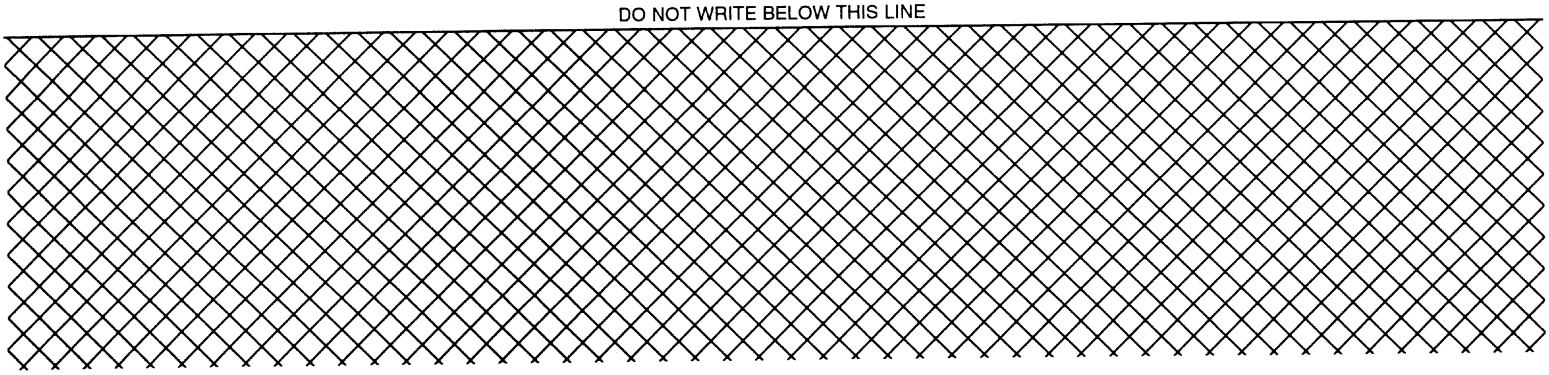
HEAD & NECK: ☐ **NORMAL** ☐ HEADACHES ☐ SINUS PROBLEMS ☐ HEARING LOSS
☐ VISUAL LOSS

SKIN:	☐ **NORMAL**	☐ CANCER	☐ PSORIASIS	☐ ECZEMA	☐ RASHES
INFECTIONS DISEASE:	☐ **NONE**	☐ HEPATITIS A / B / C	☐ HIV	☐ TUBERCULOSIS	
CANCER:	☐ **NONE**	☐ YES, TYPE: _____			
BONES:	☐ **NORMAL**	☐ OSTEOPOROSIS	☐ FRACTURES, IF YES, WHICH BONES? _____		

PLEASE USE THE SPACE BELOW TO EXPLAIN WHY YOU ARE SEEING THE DOCTOR. WHEN DID THE PROBLEM BEGIN?

PLEASE USE THE REMAINDER OF THIS PAGE TO LIST YOUR CURRENT MEDICATIONS, IF ADDITIONAL SPACE NEEDED FROM THE FRONT

DO NOT WRITE BELOW THIS LINE



7301 Medical Center Drive, Suite 400
West Hills, CA 91307
818-264-3344 FAX 818-264-3433

CENTER FOR ORTHOPAEDIC SPECIALISTS

1220 La Venta Drive, Suite 202
Westlake Village, CA 91361
805-449-0066 FAX 805-449-0016

Robert H. Fields, M.D. • Evan J. Bachner, M.D.• Eli T. Ziv, M.D.• Kevin A. Nadel, M.D. • Umesh T. Bhagia, M.D. • Andrew D. Rah, M.D. • James M. Fox, M.D.

Dear Patient,

We are pleased that you have chosen us as your physicians and we would like to welcome you to our office. Our goal is to provide you with the best medical care possible. Please fill the attached so that the doctor will have all of the necessary information to treat you. We would like to take this opportunity to acquaint you with our business office policies and we will be happy to answer any questions you may have.

- **Copayments are collected at the time of service and are not billable.**
- **We will bill you for any balance of your responsibility after we receive the explanation of benefits from your insurance company. Your patient balance will begin to accrue finance charges at the rate of 1 ½% per month (18% per year) from the 30th day after your bill is issued.**
- **Services are not rendered on a "lien" basis (deferral of payment pending the settlement of legal cases). Services are not rendered on a third party basis, meaning that we cannot bill another party's auto insurance medical pay.**

Our staff will be happy to bill your insurance for plans which we are participating providers. It is imperative that you inform us of any changes you make in your insurance coverage, such as switching to a different insurance company, policy number or a different plan within the same company (For example, if you switch from Blue Cross Prudent Buyer to Blue Cross California Care). Please inform us of changes prior to scheduling your appointment or you may become personally liable for the charges since we do not belong to all insurances plans.

I am receiving medical services based on these financial policies as indicated above. All services from the date below will be handled as follows (check one):

_____ I have health insurance and will assign my benefits. I will pay all copayments as indicated above and will pay all charges not covered by my insurance.

_____ I have no insurance and will pay for services at the time they are rendered.

Date: _____ **Signature:** _____

CREDIT CARD AUTHORIZATION **(Optional)**

Date: _____

For your convenience we accept credit card payments. You may complete this form to authorize Center for Orthopaedic Specialists to charge your credit card once we have received your insurance companies payment for services.

I authorize Center for Orthopaedic Specialists to charge this credit card for balance due after insurance has processed – Visa-MasterCard

Name: _____ Card #:_____

Signature:_____ Exp Date:_____

NOTICE OF PRIVACY PRACTICES

Center for Orthopaedic Specialists

7301 Medical Center Dr. Suite 400 West Hills, CA 91307

1220 La Venta Dr. Suite 202 Westlake Village, CA 91361

Jean Raives-Boyd- Administrator (818) 264-3344 [Privacy Officer]

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, posted on our website www.cos-orthopaedics.com, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

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.

Name and Address of Patient: _____

_____

_____

_

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CONSENT TO RELEASE

VERBAL OR WRITTEN INFORMATION

The State of California mandates that medical information may be shared only with the patient, or the patient's legal representative. In accordance with this law, every employee of **Center for Orthopaedic Specialists** is required to sign a Confidentiality Statement on an annual basis, indicating they will keep the medical information for every patient in the strictest confidence.

Adhering to the Confidentiality Policy is difficult when family members (spouses, children, and siblings) inquire about a patient's medical care. The staff and/or physicians cannot release medical information without permission from the patient or the patient's legal representative.

If you wish to give permission for staff and/or physicians to verbally release general medical information to family members, list the name(s) and relationship of those individuals in the space provided below.

General Medical Information excludes the discussion of Psychiatric Services; Drug and Alcohol; Counseling; Sexually Transmitted Diseases; HIV Testing; Pregnancy or Termination of Pregnancy.

Name	Date of Birth	Relationship

If you DO NOT wish to give permission for general medical information to be release verbally to family members, check here ☐ and sign below.

I authorize that the above individual(s) may have access to information regarding my general medical condition. I will notify **Center for Orthopaedic Specialists** if I wish to add or delete individual who may have access to my medical information.

_____ _____

Patient's Name (PRINT) Patient's Signature

_____ _____

Date Witnessed By