

NAPA VALLEY ORTHOPAEDIC



MEDICAL GROUP, INC.

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3273 CLAREMONT WAY, SUITE 100, NAPA, CA 94558 | main: 707.254.7117 | fax: 707.265.6435

**Patient Information**

Patient Name/Nombre \_\_\_\_\_

Birth date/Fecha de Nacimiento \_\_\_\_\_ Age/Edad \_\_\_\_\_ Sex/Sexo \_\_\_\_\_

How do you prefer to be addressed by our physicians and staff? \_\_\_\_\_

Como prefiere que le llamen los doctores y las personas de la oficina?

Address/Domicilio \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Ciudad, Estado, Zona Postal

Home Phone \_\_\_\_\_ Cell Ph \_\_\_\_\_

Numero de Telefono

Numero de celular

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_ Marital Status \_\_\_\_\_

Numero de Seguro Social

Licencia de Manejar

Estado Civil

Employer \_\_\_\_\_ Work Ph \_\_\_\_\_

Nombre del Empleador

Work Address \_\_\_\_\_

Domicilio del Empleador

City, State, Zip \_\_\_\_\_

Ciudad, Estado, Zona Postal

Occupation \_\_\_\_\_ Nature of Business \_\_\_\_\_

Ocupacion

Tipo de Negocio

Referred by \_\_\_\_\_

Referido por \_\_\_\_\_

Is this your Primary Care Dr \_\_\_\_\_ If no, Name of Primary Care Dr \_\_\_\_\_

Es este to Doctor Primario

Si no, Nombre del Doctor Primario.

Emergency Contact

Name/Phone \_\_\_\_\_

Contacto de Emergencia Nombre/Telefono

May we leave a message at your home? With a person \_\_\_\_ On answering machine? \_\_\_\_  
Podemos dejar mensaje en su casa? Con una persona \_\_\_\_ En la maquina de mensajes

May we leave a message at your work? With a person? \_\_\_\_ On voicemail? \_\_\_\_  
Podemoso dejar mensaje en su trabajo? Con una persona? \_\_\_\_ En el correo de voz?

Is this visit related to a Work Injury \_\_\_\_\_ If yes, Date of Injury \_\_\_\_\_  
Es esta visita relacionada con lesion de trabajo Si si, fecha de lesion

Is this visit related to an accident? \_\_\_\_\_ Is this visit related to an injury? \_\_\_\_\_  
Es esta visita relacionada con accidente? Es esta visita relacionada con lesion?

If yes, Date of Accident or  
Injury \_\_\_\_\_  
Si si, Fecha de Accidente o Lesion

Briefly describe circumstances \_\_\_\_\_  
Brevemente describa la circunstancia

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**Responsible Party if Other than Patient:**  
**Persona Responsable si otra del paciente:**

Name \_\_\_\_\_ Rel to Patient \_\_\_\_\_  
Nombre Relacion al Paciente

Address \_\_\_\_\_  
Domicilio

City, State, Zip \_\_\_\_\_  
Ciudad, Estado, Zona Postal

Phone \_\_\_\_\_ work phone \_\_\_\_\_  
Numero de Telefono Telefono del Empleador

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Nombre del Empleador Ocupacion

## Primary Insurance Company

Insurance Company Name and

Address: \_\_\_\_\_

Nombre Y Domicilio de Aseguranza

Group Number \_\_\_\_\_ ID# \_\_\_\_\_

Numero de Grupo

No de Identificacion de Aseguranza

Subscriber

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Nombre del Asegurado

Fecha de Nacimiento

Subscriber Address \_\_\_\_\_

If different from patient

Direccion del asegurado si diferente a la del paciente

Subscriber Phone: \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Telefono del Asegurado

Relacion con el asegurado

Copay Amount: \_\_\_\_\_

Co Pago

## Secondary Insurance:

Insurance company Name and

Address: \_\_\_\_\_

Nombre Y Domicilio de Aseguranza

Group Number \_\_\_\_\_ ID# \_\_\_\_\_

Numero de Grupo

No de Identificacion de Aseguranza

Subscriber

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Nombre del Asegurado

Fecha de Nacimiento

Subscriber Address \_\_\_\_\_

If different from patient

Direccion del asegurado si diferente a la del paciente

Subscriber Phone: \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Telefono del Asegurador

Relacion con el asegurador

Copay Amount: \_\_\_\_\_

Co pago

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## Welcome to Napa Valley Orthopaedic Medical Group, Inc.

Please take a few moments to assist us in gathering the necessary information for your visit with us by completing the following form.

If the answer to any of the questions is “none” please indicate this in the answer column so we know that you did not overlook the question. We would like to ensure that you had the opportunity to answer all the questions.

If you require more space to complete any answer, don’t worry. Just make a note of it with a “\*” at the end of your response and our office staff will address the question with you at the time of your visit.

### HISTORY OF PRESENT CONDITION

QUESTION	YOUR ANSWER
Tell us the area you want examined (for example – shoulder, hip, etc...)	
Your age (in years)	
Are you right or left handed?	
Date of injury	
If no date of injury how long have you had the condition?	
Tell us how your injury occurred or how the condition began.	
How often does it bother you? (e.g. every day, once a week, etc...)	
How severe is your pain on a scale of 1-10?	
Describe the quality of your pain (sharp, dull, constant, occasional)?	
When does it hurt the most?	
Does anything make your symptoms better?	
Do you have pain at night?	
Have you hurt this area before? If so, please describe.	
Please tell us any treatment of this problem or this joint that you have <u>already had previously</u> (medicines, therapy, surgery, etc...)	

**PAST MEDICAL HISTORY**

Please list any medical conditions that you have or have ever had (even if they are under good medical control at present).

1	8
2	9
3	10
4	11
5	12
6	13
7	14

Please list any surgeries you have had in the past.

1	5
2	6
3	7
4	8

Please list any complications from surgery that you have had.


**ALLERGIES**

Please list any allergies to medicines.

1	4	7
2	5	8
3	6	9

Please list any other significant allergies (for example: latex, shellfish, or betadyne)

1	4
2	5
3	6

**MEDICATIONS**

Please list all medications that you take.

1	7
2	8
3	9
4	10
5	11
6	12
Please list your pharmacy name and number	

## SOCIAL HISTORY

Do you smoke?	
If you do smoke, how many packs per day do you smoke?	
If you do smoke, for how many years have you smoked?	
Do you use tobacco products? If so, which ones?	
Do you drink alcohol?	
If you do drink alcohol, what is your preferred type of drink?	
If you do drink alcohol, how often do you drink?	
If you do drink alcohol, how many glasses do you have at each sitting?	
What is the highest level of education you have completed	

## FAMILY HISTORY

Please list any muscle or bone disorders in the following family members (for example: rheumatoid arthritis, muscular dystrophy, osteoporosis, etc...).

RELATIVE	DISORDER	DISORDER
Mother		
Father		
Brother		
Sister		

## REVIEW OF SYSTEMS

Please answer the following questions.

**Do you have any of the following symptoms?**

CATEGORY	SYMPTOM	YES	NO
General:	Fevers		
	Chills		
	Recent Weight loss		
	Recent Weight gain		
	History of Cancer		
Eyes:	Glasses		
	Double vision		
ENT:	Hearing loss		
	Problems swallowing		
	Problems speaking		
	Sinus infections		
Cardiovascular:	Heart disease		
	Heart attacks		
	Palpitations/Arrhythmia		
	High blood pressure		
Respiratory:	Asthma		
	Emphysema		

<b>CATEGORY</b>	<b>SYMPTOM</b>	<b>YES</b>	<b>NO</b>
Gastrointestinal:	<b>Acid Reflux</b>		
	<b>Stomach Ulcers</b>		
	<b>Rectal bleeding</b>		
	<b>Liver problems</b>		
	<b>Hepatitis</b>		
Genitourinary:	<b>Bladder infections</b>		
	<b>Problems urinating</b>		
	<b>Blood in your urine</b>		
	<b>Burning when you urinate</b>		
Musculoskeletal:	<b>Joint pain</b>		
	<b>Joint swelling</b>		
Skin:	<b>Rashes</b>		
	<b>Recent cuts</b>		
Neurologic:	<b>Strokes</b>		
	<b>Seizures</b>		
	<b>Numbness</b>		
	<b>Tingling</b>		
Psychiatric:	<b>Depression</b>		
	<b>Anxiety</b>		
Hematologic:	<b>Bleeding problems</b>		
	<b>Blood clots</b>		
	<b>Immune disorders</b>		
	<b>HIV/AIDS</b>		
Endocrine:	<b>Diabetes</b>		

**Thank you for taking the time to complete our questionnaire.**

**Napa Valley Orthopaedic Medical Group, Inc.**

**CONSENT FOR TREATMENT**

**Adult**

I hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

**OR**

**Complete for a Minor**

I certify that I am a legal guardian of \_\_\_\_\_, a minor, and I do hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

**INSURANCE ASSIGNMENT**

I give permission to Napa Valley Orthopaedic Medical Group, Inc. to bill my insurance carrier for services rendered. I understand that this is a service provided by Napa Valley Orthopaedic Medical Group, Inc. I request that payment of authorized Medicare or other insurance company benefits be made directly to Napa Valley Orthopaedic Medical Group, Inc., otherwise payable to me, for any services furnished to me by Napa Valley Orthopaedic Medical Group, Inc. Regulations pertaining to Medicare assignment of benefits apply.

I permit a copy of this authorization to be used in place of the original. I understand that I must inform my physician if I know that a party other than Medicare is responsible for paying for my treatment.

I understand that I am responsible for my medical bills unless I have verified coverage under an active Worker's Compensation claim. I hereby guarantee payment of all physician/provider charges and understand that any amount not paid by insurance within 60 days of service becomes my personal responsibility unless my injury is covered under an active Worker's Compensation claim. Examples of this would include but not be limited to any coinsurance, deductibles, and copayments.

**INFORMATION RELEASE**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance, information needed for this or a related Medicare or other insurance company claim. I understand that my signature requests that payment be made and authorizes release of any medical or other information necessary to pay the claim.

**PAYMENT POLICY**

It has been explained to me that if I am paying privately for medical treatment, payment of all charges is to be made in full at the time of service unless previous arrangements have been made, and I agree to pay all the charges.

If there is a co-payment for the medical service, I understand that it is due at the time of service, and I agree to make this payment.

*I have carefully read and agree to the above information.*

*Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

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**NAPA VALLEY ORTHOPAEDIC MEDICAL GROUP, INC.**

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy (5 pages) of the Napa Valley Orthopaedic Medical Group, Inc. Notice of Privacy Practices. This Notice describes how Napa Valley Orthopaedic Medical Group, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

I have been given an opportunity to take a copy of the Napa Valley Orthopaedic Medical Group, Inc. Notice of Privacy Practices to review and hereby voluntarily decline to take a copy for my own review. I have been made aware that Napa Valley Orthopaedic Medical Group, Inc. functions under the guidelines of the Health Insurance Portability and Accountability Act (HIPAA), but do not wish a hard copy of the policy at this time.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_