General Orthopedic Questionnaire

Name _____________ Date _____________

Age _____ Primary Care Physician ______________________

- What is the purpose of today’s visit? Clavicle, Shoulder, elbow, wrist/hand, hip, knee, foot/ankle (Circle all that apply)

- Rank severity of your pain from 0 to 10 (10 being extremely painful)

- How long have you had this pain?

- Is your pain occasional, frequent, or constant? (Circle one)

- Is your pain sharp, dull, stabbing? (If so, circle)

- How did this pain begin?

- Was there any injury (accident, fall, etc) involved? Yes___ No___

- If there was an injury, do you have a lawyer? Yes___ No___

- If in litigation please provide the name of the lawyer

- If Shoulder pain: Is pain aggravated with over head activity? Yes__ No__
  - Is pain worse at night? Yes__No__
  - Does pain radiate to your neck? Yes__No__
  - Do you have numbness in your hands? Yes__No__

- If Knee pain: Is your pain aggravated with climbing, squatting, twisting?
  - Does your knee give out, lock up, or swell up? (Circle all that apply)
  - Is your pain inside, outside, front, side or back of the knee?
  - What improves your pain? Rest, ice, medication, therapy, splinting?

- What type of treatment have you had up to this point? Physical therapy, chiropractic, massages therapy, medication, acupuncture, epidural injection, or surgery? (Circle all that apply. If you have had any other treatment that's not listed, please list)

Weight:___________ Height:___________
Medical History: (Circle Yes or No)

Diabetes: No
High Blood Pressure: No
Cancer: No
Stroke: No
Heart Trouble: No

Arthritis: Yes
Convulsions: No
Bleeding Tendencies: No
Acute Infections: No

High Blood Pressure: Yes
Cancer: Yes
Heart Trouble: Yes

Other Medical Condition: Yes
(If yes, please explain)

Previous Hospitalizations/Surgeries/Serious Injuries/Complications? When?

Allergies:

Patient Social History:

Career/job:
Hobbies/Sports:

Who lives at home with you?

Use of alcohol:
- Never:
- Rarely:
- Moderate:
- Daily:

If stopped, when?

Use of tobacco:
- Never:
- Previously, but quit (Date):
- Daily:
- # of packs/day:

Use of drugs:
- Never:
- Type/Frequency:

Family Medical History:

Age: Diseases: If deceased, cause of death:

Father: ___________________________ ___________________________ ___________________________
Mother: ___________________________ ___________________________ ___________________________
Siblings: ___________________________ ___________________________ ___________________________
Children: ___________________________ ___________________________ ___________________________
Review of System:

Please circle all that applies for today's visit:

- **General**: fever, chills, fatigue, night sweats, weight loss or weight gain.
- **Eyes**: diplopia, blurred vision, eye pain and redness, cataract & glaucoma.
- **ENT**: headache, hearing loss, ear pain, tinnitus, sinusitis, sore throat and hoarseness.
- **GI**: indigestion, heartburn, vomiting and bowel changes.
- **GU**: painful urination, flank pain, urgency, frequency, blood urine.
- **Nuero**: fainting, weakness and loss of coordination.
- **Musculoskeletal**: back/neck pain, muscle weakness and cramps, joint pain, edema, stiffness, and cold extremities.
- **Endocrinology**: heat/cold intolerance, weight changes, excessive thirst, excessive urination.
- **Skin**: rash, eruption, itching, pigment changes.
Please Circle area where your pain is and where it radiates to:

(Right) (Left) (Left) (Right)
(Front) (Back)

Patient Signature: ______________________ Date: ______________________
E-mail: ________________________________
Patient Registration Form

Date of Registration: _______________ Family Physician: ________________________________

DEMOGRAPHIC:
Name of Patient: ______________________ Social Security #: ____________________________
Birthday: ____________________________ Sex: _________________________________
Home Address: _______________________ City: _________________________________
State: ________________________________ Zip Code: _____________________________
Home Phone: _________________________
Work Phone: _________________________
Cell Phone: __________________________

EMPLOYER INFORMATION:
Name: ______________________________ Occupation: ______________________________
Address: ______________________________

INSURANCE INFORMATION:
Insurance: ______________________________
Policy Holder Name: __________________ Policy Holder DOB: _______________________

FAMILY CONTACT INFORMATION:
Name of Spouse: _______________________
Contact Person In Case of Emergency: ________________________________
Phone: ______________________________

I hereby authorize the medical staff to be my attending physicians and to administer to me any examination treatment, and medications he or she deems therapeutic to my complaints. I hereby authorize the release of any information to insurance carriers to process my medical claims and I irrevocably assign to the doctors at Innovative Orthopedic & Spine Surgery all payments for medical services rendered. I understand that I am responsible for payments for services not covered by my insurance company.

Signature of Patient (or responsible party-please mark relation to patient): ____________________
Medication List:

Patient Name: ____________________________

Date of Birth: ____________________________

(Please make sure to include the dosage and how you're taking them).

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________
6. ____________________________
7. ____________________________
8. ____________________________
9. ____________________________
10. ____________________________
11. ____________________________
12. ____________________________
13. ____________________________
14. ____________________________
15. ____________________________
Non-Medicare Patients Release and Assignment:

I state the above is true and correct and do here by authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician. I understand that this office will make reasonable effort to my insurance company(ies), yet, I am ultimately responsible for any balance left uncollected. If after 90 days my insurance has not paid my provider, I will be expected to pay for the outstanding balance. I am also informed that as a courtesy to patients who may be in need of an earlier appointment, our office requires at least 24 hours notification or be responsible for a $50.00 late charge or complete payment for a no show.

Signature __________________________ Date: __________________________

Medicare Patient's Please Read and Sign:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to my physician for any services furnished me by that physician. 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 this benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere of other approved claim forms or electronically submitted claims, my signature authorizes, releasing of the information to the insurer or agency shown. In determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature: ____________________________________

Date: __________________________

Members of out-of-network insurance please read and sign:

I understand that Doctor Morteza Farr, Innovative Spine Surgery are not preferred providers for: __________________________

I agree to pay any and all charges that are accumulated due to my treatment that my insurance does not pay.

Signature: __________________________ Date: __________________________
Acknowledgement of Receipt of Notice of Privacy Practices

Name of patient: ____________________________
DOB: ____________________________

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, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ___________________________________

Dated: ____________________________

If not signed by the patient, please indicate relationship: (Check please)

☐ Parent of guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient
PLEASE READ AND SIGN THIS MESSAGE AS IT EXPLAINS OUR OFFICE POLICIES

Our goal is to provide all our patients with the highest level of care and satisfaction. Please take the time to fill our Patient Data Forms out completely. Any information left blank will result in a less than productive visit.

Insurance information must be completed on our form and a copy of your insurance card is required. If you have insurance, but fail to bring your card with you at the time of the visit, you will have 24 hours to provide us with a copy either in person or by facsimile. If a card is not received within 24 hours, you will receive a statement in the mail.

You are responsible for all co-payments, co-ins, and deductibles at the time of service. Cash, all major credit cards and debit cards are acceptable payments methods also offer Care Credit to arrange payment plan. There is at least a 24 hour requirement for cancellation for appointments and a $50.00 fee will be charged for any missed appointment.

PRESCRIPTION REFILLS: All prescription refills must be faxed to our office by your pharmacy and you must allow 72 hours for processing refills. No REFILL ON ANY PRESCRIPTION OVER WEEKEND OR HOLIDAYS. REQUESTS SUBMITTED OF FRIDAYS WILL NOT BE REFILLED UNTIL THE FOLLOWING MONDAY.

FORMS: It will take no more than 2 weeks for the procession of ANY forms. We will make every attempt to complete them sooner; however, the filling out of forms is a time consuming and extremely labor-intensive process, and we are limited to non-clinical days to complete them. A fee of $20 per page is due and payable at the time forms are submitted.

REQUESTS FOR MEDICAL RECORDS: ALL of our Medical records are stored electronically and must be reviewed by the physician before release. This takes a fair amount of time. Please allow a minimum of 2 weeks for processing. There is a $0.20 per page charge and an administrative fee for processing as allowed by the state of CA. You will be notified in advance of the total charges. Payment is due prior to medical records being released.

Thank you for your cooperation.

Patient’s Name: ___________________________ Date: ______________

Responsible Party’s Name: ___________________________

I have read and agree to the above office policy:

______________________________
Signature of person Financially responsible (Relationship to Patient)