

DATE: _____ MARITAL STATUS: M W S D AGE: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ SSN: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

May we contact you by E-mail? YES NO Email Address: _____ @ _____

EMPLOYER: _____ OCCUPATION: _____

DRIVER'S LICENSE #: _____

SPOUSE: _____ SPOUSE DOB: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

HAVE YOU EVER BEEN SEEN BY A CARDIOLOGIST? YES NO NAME: _____

IS THIS ACCIDENT OR INJURY RELATED TO: AUTO JOB OTHER

DATE OF INJURY: _____

INSURANCE: _____

IS A REFERRAL REQUIRED? YES NO

HOW DID YOU HEAR ABOUT PACIFIC COAST ORTHOPAEDIC INSTITUTE?

Physician: YES NO (If yes, list name and specialty, i.e. Dr. Smith, Family Practice)

Physician Name: _____ Specialty: _____

Former Patient: YES NO Name: _____

Friend or Family YES NO Name: _____

Phone Book: YES NO White Pages Yellow Pages Online

Website: YES NO Was the website helpful? _____

Advertisement: YES NO Where was the Ad? _____

Health Fair or Expo YES NO Name and/or date of Expo _____

HISTORY AND PHYSICAL:

NAME: _____ HEIGHT: _____ WEIGHT: _____

CURRENT MEDICATIONS:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

PHARMACY: _____ PHONE: _____

DRUG ALLERGIES: _____

CHIEF COMPLAINT: _____

PAST MEDICAL HISTORY:

Please select if condition applies to your medical history:

- | | | |
|------------------------------------|----------------------------------------|------------------------------------------|
| <input type="checkbox"/> High BP | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Angina | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> TB | |

Other: _____

PAST SURGICAL HISTORY:

	<u>DATE</u>		<u>DATE</u>
Joint Replacement	_____	Gall bladder	_____
Arthroscopic Surgery	_____	Hysterectomy	_____
Neck Surgery	_____	Coronary Bypass	_____
Back Surgery	_____	Tonsil/Adenoid	_____
Hand Surgery	_____		

Other: _____

FAMILY HISTORY:

	Father	Mother	Siblings	Children	Grandparent
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High BP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY:

Have you ever smoked cigarettes? Yes No Do you currently smoke? Yes No

If you smoke, how many cigarettes do you smoke a day? (20 cigarettes = 1 pack)

Less than 1 pack 1 Pack 2 Packs
 3 Packs More than 3 packs

If you smoke, how long have you been a smoker?

Less than 1 year 1-5 years 6-10 years
 11-15 years 16-20 years More than 20 years

Do you drink alcohol?

No Yes, but no more than once a month Yes, several drinks a week
 Yes, one drink a day Yes, more than one drink a day

Do you regularly drink beverages containing caffeine?

No Yes, but not everyday Yes, one cup a day

REVIEW OF SYSTEMS:

Constitutional

Fatigue
 Weakness
 Fever
 Weight loss __ lbs
 Weight gain __ lbs
 Night Sweats

Skin

Easy Bruising
 Rashes
 Hair Loss
 Psoriasis
 Photosensitivity
 Skin Ulcers

CNS

Headache
 Dizziness
 Numbness
 Memory Loss
 Seizures

Cardiac

Chest Pain
 S.O.B.
 S.O.B./Exertion
 Swelling Feet
 Swelling Hand
 Heart Murmur
 Palpitation

Pulmonary

Cough
 Wheezing
 Lung Pain

GU

Urine Frequency
 Urethral Discharge
 Kidney Stone
 Enlarged Prostate
 Menstruation Abnormal
 Incontinence
 Frequent UTI

Endocrine

Cold Sensitivity
 Heat Sensitivity
 Polyuria
 Polydypsia
 Polyphagia
 Thyroid Problem

GI

Nausea
 Difficulty Swallowing
 Peptic Ulcer
 Abdominal Pain
 Blood in Stool
 Diarrhea

ENT

Dry Eyes
 Redness of Eyes
 Ringing of Ears
 Nose Bleed
 Mouth Ulcers
 Dry Mouth
 Blurry Vision

Musculoskeletal

Cramps
 Muscle Pain
 Swelling
 Neck Pain
 Back Pain

Allergies

Rhinitis
 Asthma
 Sinusitis

Vascular

Varicose Veins
 Vasculitis
 Blood Clots

Hematologic/Lymphatic

Enlarged Nodes
 Bleeding Tendency
 Lymphedema of arm or leg

Psychiatric

Depression
 Psychosis
 Mood change
 Anxiety

Name: _____ DOB: _____

Authorization and Assignment of Benefits:

For the services rendered and those about to be rendered, I hereby assign to Christopher C. Ninh, MD, Inc., all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the above mentioned insurance company to pay said benefits directly to Christopher C. Ninh, MD, Inc., and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to Christopher C. Ninh, MD, Inc. I understand that I am directly and primarily responsible to Christopher C. Ninh, MD, Inc., for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days) in their paying, it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all cost of collection including the filing fees as well as reasonable attorney fees. I hereby authorize Christopher C. Ninh, MD, Inc., to release to my insurance company, any information acquired including the diagnosis and the records in the course of my treatment.

Signature

Date

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be payable to Christopher C. Ninh, MD, Inc., for my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare in my behalf.

Signature

Date

Christopher C. Ninh,MD, Inc.
Statement of Policies

The following policies are established for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement of the statement of policies.

1. Christopher C. Ninh, MD, Inc., strictly provides orthopedic services only. Patients are expected to have or arrange for a Primary Care Physician. Our practice does not treat chronic pain.
2. **Deductibles and Co-Pays** are payable at the time of service. Any previous balance is expected to be paid at time of service.
3. Patients are responsible for obtaining referrals and authorizations for services rendered at Christopher C. Ninh, MD, Inc., Pacific Coast Orthopaedic Institute.
4. If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel the appointment. Failure to do so may incur a \$30.00 charge to your account for the missed appointment.
5. There is a \$25.00 fee for all disability, FMLA, and other forms/ paperwork that you need to have filled out by the physician. We may ask that you make an appointment to complete these forms.
6. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc...This charge will be determined by the information requested.
7. **Prescription Policies:**
 - a. If you are in need of a refill, please have your pharmacy fax a request to 714-432-9988. Please allow 48 to 72 hours.
 - b. No refills will be given on Friday after 2:00 PM
 - c. No pain medication will be given to post-operative patients after 90 days of surgery.
 - d. Our physicians **DO NOT** prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.

I acknowledge that I have carefully read and understand the Statement of Policies, and agree to abide by them.

Name (please print)

DOB

Signature

Today's Date