Please fax completed form to Admin RN/ Pre Reg Main OR (916) 423-6002 or OPS (916) 689-7822

Today's date_____

Surgeon _____ Surgery Date _____ Diagnosis_____ Date of Injury_____

PATIENT INFORMATION

Last Name _____ Title ____ First Name _____ Middle Initial _____

Social Security No. _____ Sex _____ Ethnicity _____

Birth Date _____ Age _____ Birth State _____

Marital Status _____ Religion _____ Primary Language _____

Interpreter Needed _____ Mailing Address _____

City _____ State _____ Zip Code _____ Country of Residence _____

Street Address (if different from Mailing Address) _____

City _____ State _____ Zip Code _____ Country _____

Home Telephone No. _____ Cell Number _____

Employment Status/Retirement Date _____ Employer _____

Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

Primary Care Physician _____

Other Physician(s) _____

SPOUSE/GUARDIAN INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Social Security No. _____ Date of Birth _____ Same Address as Patient _____

If "No" Mailing Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

Employment Status/Retirement Date _____ Employer _____

Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

EMERGENCY CONTACT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Relationship to Patient _____ Address _____

City _____ State _____ Zip Code _____

Home Telephone No. _____ Cell Number _____

INSURANCE INFORMATION – PRIMARY

Plan Name _____ Address _____

City _____ State _____ Zip Code _____ Authorization No. _____

Policy No. _____ Group No. _____ Group Name _____

Subscriber: Patient/Spouse/Guardian/Other _____ No. of Insurance Approved Days _____

If "Other" Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Sex _____ Employment Status/Retirement Date _____

Employer _____ Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

INSURANCE INFORMATION – SECONDARY

Plan Name _____ Address _____

City _____ State _____ Zip Code _____ Authorization No. _____

Policy No. _____ Group No. _____ Group Name _____

Subscriber: Patient/Spouse/Guardian/Other _____ No. of Insurance Approved Days _____

If "Other" Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Sex _____ Employment Status/Retirement Date _____

Employer _____ Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

CYRA Phone Interpreter No. _____ Additional Notes _____

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physicians, our office staff and others outside of our office that our involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required uses and Disclosures Will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in the notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

1. NAME: _____

2. DATE OF INJURY: _____ TODAY'S DATE _____

3. **MAIN PROBLEM:** Please describe problem that requires evaluation today. _____

_____

_____

4. **HISTORY OF PRESENT PROBLEM:** How did this problem start or happen? _____

_____

_____

_____

_____

5. **PAST HISTORY:**

A. Any previous problems in this same area? Please descirbe (include dates). _____

_____

B. Please describe any fractures or all other injuries you may have had. _____

_____

_____

C. Do you have any family history or serious diseases? (Heart disease, diabetes, cancer, arthritic problems, birth defects, etc.)? Please describe.

_____

_____

_____

D. Please describe any previous surgeries of any kind which you may have had. _____

_____

_____

E. Please describe any hospitalizations you may have had, excluding, the above surgeries. _____

_____

_____

F. Please describe any medication you are allergic to and the reactions you have to them. _____

_____

G. Please list any medications you take currently. _____

_____

H. Do you smoke? _____ How Much? _____

I. Do you drink alcohol? _____ How Much? _____

J. Do you take illegal drugs? _____ How Much? _____

6. **REVIEW OF SYSTEMS:** Please circle appropriate responses and list information in the space provided at the end of the review of systems.

A. RESPIRATORY: Do you have: Asthma, TB, wheezing, history of pneumonia, other? _____

B CARDIOVASCULAR: Do you have a history of: Hypertension, myocardial infarction, irregular heartbeat, other? _____

_____

C. GASTROINTESTIONAL: Do you have a history of: Nausea, vomiting, ulcers indigestion, rectal bleeding, hepatitis, weight loss, other? _____

D. Genitourinary: have you had: Kidney stones, syphillis, gonorrhea, changes in urinary habits, other? _____

_____

females: pregnancies _____ live births _____ miscarriages or abortions _____

E. ENDOCRINE: Do you have a history of: Diabetes, thyroid disease, other? _____

F. NEUROMUSCULAR: Do you have a history of fractures, congenital anomalies, arthritic conditions, other? _____

_____

G. PSYCHOLOGICAL: Do you have a history of psychiatric disease or treatment: YES NO

H. NEUROLOGICAL: Do you have a history of: siezures, epilepsy, tumors, other? _____

I. Describe any of the above: _____

_____

_____

_____

7. **OCCUPATION:** _____ how long: _____

Amount of time off work due to injury _____

8. VITAL SIGNS

Height: _____ Race: _____

Weight _____ Dominant Hand: _____

Age: _____ Sex: _____

THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

NAME: _____

DATE: _____

Capital Orthopedics
ORTHOPEDIC SURGERY & SPORTS INJURIES

Diplomates
American Board of Orthopedic Surgery

Fellows
American Academy of Orthopedic Surgery

Qualified Medical Examiners
State of California

CAPITAL ORTHOPEDICS
ORTHOPEDIC SURGERY & SPORTS MEDICINE

PATIENT ACKNOWLEDGEMENT

Patient Name:_____

- **My signature constitutes assignment of benefits for services performed by the providers of Capital Orthopedics and/or Dr. Daniel D'Amico; a photocopy of this assignment is considered as valid as the original. Capital Orthopedics and/or Dr. Daniel D'Amico may release information that may be necessary to secure payment from my insurance. I understand that I am financially responsible for claims that are denied or delayed by my insurance and that co-pays and/or deductibles are due at the time of service.**

- **Workers' Compensation: I understand that the providers of Capital Orthopedics and/or Dr. Daniel D'Amico provide treatment and reporting in compliance with the State of California Labor Code.**

- **I understand that I or my account guarantor is responsible to pay, within 30 days, the amount billed on any service denied as noncovered by my insurance policy. I hereby permit a copy of this authorization to be used in place of the original.**

_____ _____

Signature of Patient **Signature of Parent or Guardian**

Date:_____ **Date:**_____

Harry A. Khasigian, M.D. ◆ **(916) 525-0620** ◆ (916) 525-0639 Fax
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