Patient Sign-In Sheet

(Please Print)

Today's Date _____

Patient _____ (First / Middle Init. / Last Name) Social Security No. _____

Address _____ (Street / City / Zip) Telephone (____) _____

Occupation _____ Birth Date _____ Age _____ Sex _____

Driver's License No. _____

Employer-Name _____ Telephone (____) _____

Address _____

Married ☐ Single ☐ Divorced ☐ Widow(er ☐

Spouse/or Responsible Parent _____ (First / Middle Init. / Last Name) Social Security No. _____

Address _____ (Street / City / Zip) Telephone (____) _____

Occupation _____ Birth Date _____ Age _____ Sex _____

Driver's License No. _____

Employer-Name _____ Telephone (____) _____

Address _____

IN CASE OF EMERGENCY—(Other than husband or wife)—Person not living with you:

Name _____ Relationships _____

Address _____ (Can be out-of-town / Street / City / State) Telephone (____) _____

PLEASE COMPLETE IF PATIENT IS UNDER 21 YEARS OF AGE OR A STUDENT:

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Father's Employer _____ Mother's Employer _____

Address _____ Address _____

MEDICAL INSURANCE (To be completed in all cases)

Primary Insurance Subscriber _____ Secondary Insurance Subscriber _____

Insurance Co. _____ Insurance Co. _____

Billing Address _____ Billing Address _____

Identification Number _____ Identification Number _____

Group Number _____ Group Number _____

IF INJURY, WHEN AND HOW DID IT HAPPEN?

Home ☐ Work ☐ Automobile ☐ Other _____

Date _____ Hour _____ Last Worked _____

If industrial injury, name and address of employer at time of injury _____

Industrial Insurance Carrier:

Name & Address _____ Claim # _____

REFERRED TO THIS OFFICE BY (Please include address and telephone number of referring doctor)

Is Patient bringing outside x-rays? _____ From? _____

AUTHORIZATION:

The undersigned patient, or authorized individual acting on behalf of the patient understands and agrees as follows:

1. Doctors GREENBAUM. . . . . reserve the right to designate any qualified physician to perform and administer care and treatment of the patient.
2. Doctors GREENBAUM. . . . . are granted permission to release to the insurance carrier, employer, their representatives or referring physician, any information in connection with any treatment rendered to patient, or in patient's behalf at any time such information is requested.
3. I authorize payment of medical benefits to the doctor rendering services.
4. Patient shall pay to Doctors GREENBAUM. . . . . such sums as are or may become due for services rendered to the patient, it being understood that in the event patient's insurance company, if there be any, does not make payment, or only a partial payment, this obligation shall be binding personally upon patient.

_____ Date

_____ Patient, Parent, Guardian

WORKERS' COMPENSATION HISTORY

PLEASE FILL IN THE FORM AS COMPLETELY AS POSSIBLE. NOTIFY OUR STAFF IF YOU HAVE ANY QUESTIONS; THEY WILL BE GLAD TO HELP YOU.

Patient's Name:_____ Date:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____ Work Phone:_____

Social Security #:_____ Driver Lic # _____

Date of Birth:_____ Age:_____ Sex: F M Right/Left Handed

Height:_____ Weight:_____ Smoker:_____ Married: Y N

Nearest Relative:_____ Phone:_____

INJURY INFORMATION

Date of Injury:_____ Time of injury:_____

Employer at time of injury:_____

Date of hire:_____ Length of time worked:_____

Date Claim Filed:_____ Last Date of Employment:_____

Please list all body parts injured:_____
_____

Prior to the date(s) above have you ever injured the same area(s) of your body?_____
Did you have a pre-employment physical examination? Yes No

Any work restrictions based on that exam? Yes No Explain:_____

Describe how the injury happened: (Did you fall, were you struck by something, were you in an auto accident, were you using special equipment, etc…)
Describe what part of your body was injured in the accident:_____

What kind of pain or discomfort did you experience at the time of injury?_____
_____

Did you report the accident at the time of injury? Yes No If so to whom?_____

Were there any witnesses to the accident, if so, who?_____

PAST MEDICAL TREATMENT

What occurred immediately after the accident? (Were you provided with medical treatment, etc...)_____

Did you go to a hospital? Yes No Clinic? Yes No When?_____

If you did not seek or receive medical treatment immediately following the incident, when, and for what reason, did you first seek or receive medical care?

_____

Name of Doctor: _____ M.D. D.O. Chiropractor?
Treatment: _____
Frequency and duration of the treatment: _____
Who referred you to the Doctor/Chiropractor? _____

Did you see any other doctors/chiropractors prior to presenting to our office? _____
Name of Doctor: _____ Date seen: _____
Type of treatment rendered:_____

CURRENT TREATMENT

Name of Doctor:_____ Diagnosis: _____
Treatment rendered: _____
Chiropractor's Name: _____ Diagnosis: _____
Treatment: _____
Who referred you to Chiropractor: _____
How long is each treatment:_____ How often: _____
Is it helping? _____ How long have you been treating? _____

PHYSICAL THERAPY: What does the therapist do for treatment? _____

How long is the treatment? _____ How often? _____ Does it help?

WC HISTORY

Following your first medical care, did you see any other doctors or undergo any special

Tests? MRI, CT SCAN, X-RAY If so, please list the doctor or facility visited and briefly state why you saw them (referred by someone else or due to pain and discomfort, etc)
What were the findings on the tests? _____

CURRENT COMPLAINTS? _____

What did the doctor say was wrong with you? _____

What makes the pain better? _____
What makes the pain worse? _____
When or how often do you experience pain? _____

PAST MEDICAL HISTORY

Personal doctor/chiropractor: _____
City: _____ Phone: _____

Your personal doctor has treated you for the following: PLEASE LIST

Do you have or have you ever had any of the following (Please circle)

Alcoholism	Y	N	Gout	Y	N
Anemia	Y	N	Heart trouble	Y	N
Arthritis	Y	N	High Blood pressure	Y	N
Edema (swelling)	Y	N	Kidney disease	Y	N
Bleeding disorder	Y	N	Liver disease	Y	N
Cancer	Y	N	Mental Illness	Y	N
Diabetes	Y	N	Migraine headaches	Y	N
Emphysema	Y	N	Stomach ulcers	Y	N
Epilepsy	Y	N	Stroke	Y	N
Glaucoma	Y	N	Tuberculosis	Y	N
Drug Abuse	Y	N	HIV – Aids virus	Y	N

Other serious diseases _____
Previous motor vehicle accidents _____ Date: _____
Previous Work Comp accidents _____ Date: _____
Previous wounds/burns _____ Date: _____

Orthopeadic problems (describe) _____

Operations (please circle)

Appendix	Y	N	Date/Age: _____
Gallbladder	Y	N	Date/Age: _____
Hernia	Y	N	Date/Age: _____
Hysterectomy	Y	N	Date/Age: _____
Stomach	Y	N	Date/Age: _____
Tonsils	Y	N	Date/Age: _____

Other operations or surgeries: _____

Have you been hospitalized for any other problems? Please describe: _____

Do you have any other claims or suits pending? Yes No Explain: _____

Are you currently taking ANY medications? Please list: _____

Are you allergic to any medications? Please list: _____

How and when did you discover you had allergic problems? _____

FAMILY HISTORY

Father: Alive / Deceased Age: _____ Health: _____
Mother: Alive / Deceased Age: _____ Health: _____
Do you have brothers? Yes No How many? _____ Health: _____
Do you have sisters? Yes No How many? _____ Health: _____

PERSONAL & SOCIAL HISTORY

Do you smoke? Yes No If so, how much? _____ Since: _____
Do you drink? Yes No If so, who often? _____ Since: _____
Do you drink Wine? _____ Beer? _____ Hard Liquor? _____

Marital status (circle) SINGLE MARRIED DIVORCED WIDOWED SEPARATED
Children? _____ How many? _____ Ages: _____

Country of birth: _____ How long in the U.S.? _____

Highest level of education: _____
Completed _____ Grade _____ Year _____

Military history: Branch _____ Date entered _____ Date discharged ____

Type of discharge: _____

OCCUPATIONAL HISTORY

Employer at the time of injury _____
Date of Hire: _____ Job title: _____
Work hours: _____ to _____ Days: M T W Th F S Sun

Work restrictions when hired? Yes No If so, please list: _____
Are you presently working for the same company where you were injured? Yes No
If not, when did you leave your employer? _____ Why? _____
If you have a new employer, what is your current job description? _____
Employer's name: _____ Location? _____
When did you start the new job? _____
What are your physical duties at the new job? _____

Are you full time? Yes No Part time? Yes No
Any restrictions? Yes No What are they? _____

If you are not presently working, are you seeking a new job? _____
How long have you been off work? _____
Who advised you to be off work? _____
If you are on medical leave, when are you expected to return to work? _____

List employer(s) and dates of employment BETWEEN the job in which you injured yourself and your current employer: _____

Do you feel you are able to return to work? Yes No In what capacity?

PAST EMPLOYERS

Employer	Dates worked	Job title	Injured
1.			
2.			

3. _____

PLEASE NOT THE FOLLOWING INFORMATION PERTAING TO THE SPECIFIC JOB REQUIREMENTS AT THE TIME OF INJURY

General job description at the time of injury: _____

Divide you typical 8 hour day into SITTING, STANDING, and WALKING

SITTING	1	2	3	4	5	6	7	8 Hours
STANDING	1	2	3	4	5	6	7	8 Hours
WALKING	1	2	3	4	5	6	7	8 Hours

NOTE: OCCASIONAL 33% of the time

FREQUENTLY 33-66% of the time

CONTINUOUS 66-100% of the time

You were required to lift:

	NEVER	OCCAS	FREQ.	CONTINUOUS
Up to 10 pounds	_____	_____	_____	_____
11 to 20 pounds	_____	_____	_____	_____
21 to 50 pounds	_____	_____	_____	_____
51 to 100 pounds	_____	_____	_____	_____

You were required to lift and carry:

	NEVER	OCCAS	FREQ	CONTINUOUS
Up to 10 pounds	_____	_____	_____	_____
11-20 pounds	_____	_____	_____	_____
21-50 pounds	_____	_____	_____	_____
51-100 pounds	_____	_____	_____	_____

You were required to use your hands for repetitive action such as:

	FINE MANIPULATION		SIMPLE GRASPING		PUSHING/PULLING	
RIGHT	YES	NO	YES	NO	YES	NO
LEFT	YES	NO	YES	NO	YES	NO

You were required to use your feet in repetitive movements (as in operating foot controls)
RIGHT: YES NO LEFT YES NO

You were required to:

	NEVER	OCCAS	FREQ	CONTINUOUS
Bending	_____	_____	_____	_____
Squatting	_____	_____	_____	_____
Crawling	_____	_____	_____	_____
Kneeling	_____	_____	_____	_____
Climbing	_____	_____	_____	_____
Walking on Uneven ground	_____	_____	_____	_____
Working above Ground	_____	_____	_____	_____
Reaching above Shoulder level	_____	_____	_____	_____
Reaching at Shoulder level	_____	_____	_____	_____
Reaching below Shoulder level	_____	_____	_____	_____

Please list types of machines, tools, or other equipment used in your job: At the time of injury_____

Please list vehicles or moving equipment operated as part of your job: At the time of injury_____

DISCLOSURE STATEMENT

THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

Signature_____ DATE_____

INTERPRETER:

If an interpreter has been used to complete this Worker's Compensation History,please provide the information below:

_____ Home Phone# _____

(Print your name)

ORANGE COUNTY
ORTHOPAEDICS &
SPORTS MEDICAL GROUP, INC.

BRADLEY S. GREENBAUM, M.D.

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
    - Treatment
    - Payment
    - Health Care Operations
    - Notifications
    - Marketing
    - Research
    - Special Circumstances and the Law
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number shown at the bottom of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices:

Signature	Printed Name	Date

15825 Laguna Canyon Rd. Suite 103 Irvine, California 92618 949.451.1454 Fax. 949.451.1452

ORANGE COUNTY
ORTHOPAEDICS &
SPORTS MEDICAL GROUP, INC.

BRADLEY S. GREENBAUM, M.D.

OUR PRIVACY PROMISE TO OUR PATIENTS

YOUR INFORMATION IS IMPORTANT AND CONFIDENTIAL. OUR POLICY REQUIRES THAT YOUR INFORMATION IS HELD IN COMPLETE CONFIDENCE.

Authorization to leave messages

I give my permission for the staff of Orange County Orthopaedics & Sport Medical Group, Inc. to leave messages on my telephone answering machine or with a family member such as information regarding medication, surgery, appointments and health care.

_____ _____

Signature of Patient Date

_____

Patient Name – Please Print

_____ _____

Family Member's Name Family Member's Name

I do **not** give permission for the staff of Orange County Orthopaedics & Sports Medical Group to leave messages on my telephone answering machine or with family members.

_____ _____

Signature of Patient Date

_____

Patients Name – Please Print

5825 Laguna Canyon Rd. Suite 103 Irvine, California 92618 949.451.1454 Fax. 949.451.1452

ORANGE COUNTY ORTHOPAEDICS AND SPORTS MEDICAL GROUP, INC FINANCIAL POLICY

CO-PAYS AND DEDUCTIBLES

All Co-pays and Deductibles are required to be paid at the time of service. In the event of an emergency and the patient does not have the means to pay for Co-Pays, the patient will be given an envelope to mail the Co-pay, if Co-Pay is not received within 2 weeks a Statement will be mailed to the patient and a statement fee of $10.00 will be added to the Co-Pay.

HEALTH INSURANCE

Orange County Orthopaedics & Sports Medical Group, Inc will bill your health insurance carrier as a courtesy to you if presented with the information and assignment of benefits at the time of service. All applicable co-pays and deductibles must be paid at the time of service.

PAYMENT RESPONSIBILITY

An anticipated insurance payment does not replace the patient's obligation to pay any outstanding balance. If insurance payment is not received within 60 days of the date of service, the patient will be held responsible for payment.

RETURNED CHECKS

There will be a $25.00 fee for any returned checks, and all discounts will be voided, patient will be responsible for full fees for services received plus the $25.00 returned check fee.

WORKER'S COMPENSATION

It is required at the time of service that the patient gives Worker's Compensation and health insurance information. Charges for services incurred as a result of a work-related injury will be billed to the Worker's Compensation carrier or the employer. Upon denial by Worker's Compensation, the health insurance carrier or the patient will be responsible.

MANAGED CARE (HMO)

Unless an authorization is obtained from your PCP, or your health care carrier, you will be responsible for payment in full at the time of service. Your insurance will be billed as a courtesy to you.

REFUNDS

All refunds must be requested in writing and a refund check will be mailed to the appropriate party within 2 weeks.

"I have read, understand and agree to the provisions of this policy."

_____ _____

Patient/Legal Guardian Signature Date