ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

○ ROBERT G. APTEKAR, M.D. ○ MICHAEL D. BUTCHER, M.D. ○ DALJEET S. SAGOO, D.O.

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Welcome to AOMC! We look forward to giving you the best medical experience possible. Please complete both sides of this form. Let us know if you need any assistance with it.

PATIENT INFORMATION

Patient's last name: First: Middle: Today's Date:

Email Address :

Social Security no.: Date of Birth: / / Best phone to contact you? ( )

Home street address: City: ZIP Code: Age: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ W Phone #: ( )

How did you learn about our practice?

❑ Family ❑ Friend ❑ Yelp ❑ Google ❑ Internet search

If family or friend, whom may we thank?

Is this person a patient in our office? ❑ Yes ❑ No

Recommended by another provider; If so whom may we thank?

Have you visited our website? ❑ Yes ❑ No

INSURANCE INFORMATION

(Please provide us with your insurance cards.)

Do you have medical insurance? ❑ Yes ❑ No

Please indicate primary insurance: Group # Union/Local #

Subscriber's name: Subscriber's S.S.#.: Birth date: / / Group no.: Policy no.: Co- payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of employer: Work phone:

Employer address:

IN CASE OF EMERGENCY

Emergency Contact Person: Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

Email address of Emergency Contact :

Family Doctor: Office No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Parent/Guardian Signature: Date:

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MEDICAL

Chief Complaint:

Related to: ❏ Work ❏ Auto Accident ❏ Sports ❏ Home ❏ Other Body Part(s) _________________ ❏ Right ❏ Left

If work related, Employer at time of accident? Date of injury:

Employer: Phone: ( ) Fax: ( )

Address: City: State: Zip:

Occupation: Supervisor: Employee Email Address:

❏ Work Related ❏ Auto Accident (Please provide us with any affiliated paperwork)

Insurance Carrier: Claim/Policy Number

Claim Address: City: State: Zip:

Claim Adjuster/Examiner: Phone: ( ) Fax: ( )

Mailing Address (if different from above)

Attorney Name: Phone: ( ) Fax: ( )

Address: City: State: Zip:

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ADDITIONAL STATEMENT OPTIONS

Not all services are covered by insurance. In the even you insurance plan determines a service to not be covered, you will be responsible for the complete charge. Our staff cannot guarantee you eligibility and coverage. Insurance rules and limits vary with insurance plans. If your plan denies a service, you will be responsible for the charge. We do not base your treatment plan on what your insurance plan covers or does not cover.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my own health. I authorize the physician to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the physician or medical group insurance benefits otherwise payable to me.

A $25 fee will be charged for all same day notice or appointment cancellations / no shows.

I certify that I have read and understand this form to the best of my knowledge. I have answered every question completely and accurately. I will inform my physician of any change in my health and/or medication. Furthermore, I will not hold my physician, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

I hereby assign to **Arthritis & Orthopedic Medical Clinic** any and all medical benefits otherwise payable to me for medical health treatment rendered by **Arthritis & Orthopedic Medical Clinic** described in the attached claim form. I acknowledge that I am still responsible for paying the above-referenced physician to the relevant insurer or payer does not pay the physician in full.

Signature of Patient Date

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

Name: ____ DOB:______________ Today's Date: ____________________

Height:______________ Weight:____________

PRESENT ILLNESS: What medical problem brings you to the office?

____

Is this problem related to an injury?_____________ When?_________________ Work Related?___________________

What treatments have you received?____

____

List in chronological order all hospitalizations, serious illnesses, operations, severe injuries and fractured bones.

Conditions/Operations Date/Year Hospital City/State Physician's Name

1. ____
2. ____
3. ____

your medical condition. Please list any other Doctors who currently/or have previously treated you.

Physician's Name/Specialty Address Telephone No.

1. ____
2. ____

Any Recent X-Rays, MRI, CT scan? (Please list below)

____

HAVE YOU EVER BEEN TREATED WITH OR TAKEN ANY OF THE FOLLOWING:

☐ Ibuprofen ☐ Celebrex ☐ Naproxen ☐ Other NSAIDS ____

☐ Cortisone Injection ☐ Steroids ☐ Other: ____

Are you allergic to any drug? ☐ Yes ☐ No If yes, Which ones? _______________ Reaction?______________________

PAST MEDICAL HISTORY: ***(Have you ever had any of the following? Please list the year.)***

☐ Heart Attack___________ ☐ Hepatitis___________ ☐ Diabetes__________ ☐ Gallstones____________

☐ Cancer_____________ ☐ Ulcers_____________ ☐ HIV/Aids__________ ☐ Kidney Problems__________

☐ High Blood Pressure_____________ ☐ Other:____

For each check above, list ***the condition*** and ***its treatment:***

____

SOCIAL HISTORY:

Present Occupation:_____________________________ How long?____________________ Birth place?______________

☐ Smoke?____________ ☐ Pks/Day?___________ ☐ Drink Alcohol?___________ ☐ Drinks per day?____________

☐ Special Diet?____

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

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Patient Name:___________________________________ Age:__________ Date:____________________

MEDICATIONS

Medication	*Dosage*	*Frequency*	*Prescribing Dr.*

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

Name:____

Date:_____________________________________

Please read the following questions carefully and mark your answer by completely filling in the appropriate bubbles: Correct ● Incorrect O

Review of Symptoms: Do you ***PERSISTENTLY*** experience any of the following?

Unexplained fever > 101 degrees	O Yes	O No
Unexplained weight gain > 30 lbs	O Yes	O No
Continuous loss of appetite	O Yes	O No
Permanent loss of smell	O Yes	O No
Frequent night sweats	O Yes	O No
Unexplained weight loss < 30lbs	O Yes	O No
Unexplained severe dry mouth	O Yes	O No
Constant ringing in ears	O Yes	O No
Unexplained severe skin rash	O Yes	O No
Raynaud's	O Yes	O No
Unexplained hives	O Yes	O No
Diabetes	O Yes	O No
Unexplained frequent excessive thirst	O Yes	O No
Severe frequent dizziness	O Yes	O No
Frequent palpitations	O Yes	O No
High blood pressure	O Yes	O No
Unexplained persistent cough	O Yes	O No
Asthma	O Yes	O No
Unexplained severe abdominal pain	O Yes	O No
Blood in stool	O Yes	O No
Unexplained severe vomiting	O Yes	O No
Unexplained persistent swollen glands	O Yes	O No
Blood in urine	O Yes	O No
Unexplained frequent burning with urination	O Yes	O No
Seizures	O Yes	O No
Tremors	O Yes	O No
Nightly restless leg symptoms	O Yes	O No
Panic attacks	O Yes	O No
Suicidal thoughts	O Yes	O No
Are you receiving counseling	O Yes	O No

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

Name:____

Date:_______________________________________

Please read the following questions carefully and mark your answer by completely filling in the appropriate bubbles: Correct ● Incorrect o

Social History

Are you currently working?	O Yes	O No
Are you married?	O Yes	O No
Do you smoke?	O Yes	O No
Do you drink more than three alcoholic beverages per day?	O Yes	O No

Family History

Is your Mother Alive?	O Yes	O No
Is your Father Alive?	O Yes	O No
Are your Siblings Alive?	O Yes	O No
Are your Children Alive?	O Yes	O No

Past Medical History

Are you Allergic to any medications?	O Yes	O No

If you marked "yes" above please complete the following by circling "yes" or "no" and marking the box that best describes you allergic reaction to the drug:

Aspirin

Yes No *Reaction:* Rash☐ Hives☐ Shortness of Breath☐

Codeine

Yes No *Reaction:* Rash☐ Hives☐ Shortness of Breath☐

NSAIDS

Yes No *Reaction:* Rash☐ Hives☐ Shortness of Breath☐

Penicillin

Yes No *Reaction:* Rash☐ Hives☐ Shortness of Breath☐

Sulfa

Yes No *Reaction:* Rash☐ Hives☐ Shortness of Breath☐

Morphine

Yes No *Reaction:* Rash☐ Hives☐ Shortness of Breath☐

Tramadol

Yes No *Reaction:* Rash☐ Hives☐ Shortness of Breath☐

Would you like us to assist you in stopping smoking? ☐ *Yes* ☐ *No*

221 East Hacienda Ave Suite A * Campbell, CA 95008
Tel. (408) 356-0444 Fax: 408-358-5125

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

Name:____

Date:_________________________________

Please clearly mark any past surgeries that apply by completely filling in the appropriate bubbles:

Correct ● Incorrect ⊗ ⁄

Surgical History:

Trigger finger release	O Yes	O Right	O Left
Hand Surgery	O Yes	O Right	O Left
Carpal tunnel release	O Yes	O Right	O Left
ORIF, wrist	O Yes	O Right	O Left
Shoulder Arthroscopy	O Yes	O Right	O Left
Foot surgery	O Yes	O Right	O Left
Ganglion cyst excision	O Yes	O Right	O Left
Knee Arthroscopy	O Yes	O Right	O Left
Total knee arthroplasty	O Yes	O Right	O Left
ACL repair	O Yes	O Right	O Left
Total hip arthroplasty	O Yes	O Right	O Left

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

March 29, 2017

To comply with Health and Portability regulations of the government, we need to ask for the following demographic information. This information is only to facilitate the tracking of services for the US Healthcare Reporting Services. The categories and choices are from the government reporting regulations.

Race:
1. Asian
2. Native Hawaiian/Other Pacific Islander
3. Black of African American
4. White
5. Other Race
6. Other Pacific Islander
7. Refuse to Report

Language:
1. English
2. Other (Please provde language)
3. Indian (includes Hindi and Tamil)
4. Spanish
5. Russian

Ethnicity:
1. Hispanic or Latino/Latina
2. Not Hispanic of Latino/Latina
3. Refuse to Report

Smoking:
1. I smoke now.
2. I previously smoked.
3. I have never smoked.
4. I decline to answer.

Alcoholic beverages:
1. I drink less than three drinks per day.
2. I drink more than three drinks per day.
3. I don't drink.
4. I decline to answer.

Hypertension/High Blood Pressure:
1. Are you being treated for hypertension?
    a. Yes
    b. No

We appreciate your cooperation in this matter.

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

March 29, 2017

TO ALL PATIENTS OF AOMC

We are delighted to announce a new “Patient Portal” to allow you as a patient to access our office on the internet. This access is through your email and is a completely HIPPA complaint, secure website allowing communication to and from our patients to our office.

Patient will be able to access forms to fill out as new patient, request, change or cancel appointment or communicate with our staff. There will be additional feature added over time.

If you would like to access this website and participate in our “Patient Portal”, please sign below, giving us your email. We will then set up a username and password, emailing it to you as well as the web address, so you can get started.

We hope you find this new system beneficial. As always, please let us know what you think of the new system.

Sincerely,

Robert G. Aptekar, M.D. Michael D. Butcher, M.D. Daljeet S. Sagoo, D.O.

Yes, I would like to have access to the new AOMC website Patient Portal.

Name:____

Email:____ Date: _____________________________

Arthritis & Orthopedic Medical Clinic

221 E. Hacienda Ave. Suite A
Campbell, CA 95008

ALCOHOL

Name: |Aomc Test Gender: | Date:

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?

- ☐ Never (0 points)
- ☐ Monthly or less (1 point)
- ☐ Two to four times a month (2 points)
- ☐ Two to three times per week (3 points)
- ☐ Four or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 (0 points)
- ☐ 3 or 4 (1 point)
- ☐ 5 or 6 (2 points)
- ☐ 7 to 9 (3 points)
- ☐ 10 or more (4 points)

If 'Yes' : How often did you have six or more drinks on one occasion in the past year?

- ☐ Never (0 points)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

Points | 0

Interpretation

- ☐ Positive
- ☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0 - 12 (scores of 0 reflect no alcohol use).

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.

ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

221 E. Hacienda Ave. Suite A
Campbell, CA 95008

ROBERT G. APTEKAR, M.D.
Board Certified, Orthopedic Surgery

MICHAEL D. BUTCHER, M.D.
Board Certified, Orthopedic Surgery

DALJEET S. SAGOO, D.O.
Board Certified, Orthopedic Surgery

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: ● Protected health information may be disclosed or used for treatment, payment, or healthcare operations. ● The practice reserves the right to change the privacy policy as allowed by law. ● The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. ● The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. ● The practice may condition receipt of treatment upon execution of this content.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____
____
____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: _________

Witness: ____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization shows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: ____

Physician/Healthcare Facility

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: ARTHRITIS AND ORTHOPEDIC MEDICAL CLINIC

Name

221 E. Hacienda Ave. Suite A

Address

Campbell CA 95008

City *State* *Zip Code*

The medical information/records will be used for the following purpose: ____________________

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information: ______________________________________

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _______(initial)

Psychiatric/Mental Health _______(initial)

Tests for Antibodies to HIV _______(initial)

HIV Diagnosis/Treatment _______(initial)

Genetic Information _______(initial)

DURATION This authorization shall be effective immediately and remain in effect until ________

Date

RESTRICTIONS

Permissions for further or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

____
Signature of patient or legal/personal representative

____
Relationship (*if other than patient*)

____
Patient’s Name (PRINT)

____
Date

____
Patient’s Social Security Number

____
Patient’s Date of Birth

____
Witness name

____
Witness signature