DOCTOR: _____ PATIENT ACCT # _____

PATIENT INFORMATION FOR MEDICAL RECORDS – PLEASE PRINT

Last Name _____ First Name _____ M _____

Home Address _____ City _____ State _____ Zip Code _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Work Phone ( )_____ Cell Phone ( ) _____

Sex M F Marital Status S M Birth Date _____/_____/_____

Social Security Number _____ / _____ / _____ Age _____

Patient's Employer _____ Occupation _____

Referred by Whom _____ *Family Physician* _____

In case of Emergency Contact _____ *Relationship to Patient* _____

Home Phone ( ) _____ *Work Phone ( )* _____

IF PATIENT IS A MINOR, PLEASE COMPLETE USING PARENT INFORMATION:

Father's Name _____ Employer _____

Work Phone ( ) _____ Social Security Number _____

Mother's Name _____ Employer _____

Work Phone ( ) _____ Social Security Number _____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY? YES NO

PRIMARY INSURANCE

Insurance Co _____

If HMO which IPA: Seaview Valley Care Ojai Valley BVMG

Subscriber # _____

Group # _____

Subscriber _____ DOB:_____

Subscribers Relationship to Patient_____

Co-payment $ _____

SECONDARY INSURANCE

Insurance Co _____

If HMO which IPA: Seaview Valley Care Ojai Valley BVMG

Subscriber # _____

Group #_____

Subscriber_____ DOB:_____

Subscriber's Relationship to Patient _____

Co-payment $ _____

CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

AUTORIZATION FOR MEDICAL TREATMENT, RELEASE OF MEDICAL INFORMATION AND FINANCIAL AGREEMENT.

I/WE DIRECTLY ASSIGN ALL MEDICAL/SURGICAL BENEFITS TO THE ORTHOPEDIC SURGEON AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE ORTHOPEDIC SURGEON TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

_____ _____ _____

Patient Signature or Legal Guardian Print Name Date

168 N. Brent, Suite 505
Ventura, CA 93001
(805) 648-3902

ORTHOPEDIC SURGERY

Notice of Health Information Privacy Practices

This notice describes how information about you may be used and disclosed, and how you may get access to this information. Please review it carefully.

At our office, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 4/14/03, and applies to all protected health information as defined by federal regulations.

Each time you visit our office, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical records, serves as a:

- Basis for planning your care and treatment,
- Means of communication among health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer receive information required for billing,
- A source of information for public health officials, when/if they require access to our records,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used, helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and to make an informed decisions when authorizing disclosure to others.

Although your health record is the physical property of our office., the information belongs to you. You have the right to:

- Obtain a copy of this Notice of Information Practices upon request,
- Inspect and copy your health record, and we may charge you a reasonable fee for copies.
- Request an amendment to your medical record in writing. We may, or may not make a change in your record, however we will include your statement in your file. Either way, we will not remove or alter earlier documents.
- Obtain an accounting of the disclosures of your health information.
- Request communications of your health information by alternative means or at an alternative location.
- Request a restriction on certain uses and disclosures of your information in writing. and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

We are required to:

- Maintain the privacy of your health information,
- Advise you of our privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or location.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide you with a revised notice.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer, Tracy Ward at 168 N. Brent St. Suite 505, Ventura, (805) 648-3902 or with the Office for Civil Rights, U. S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.
There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

The law provides use or disclosure of your health information for treatment, payment and operations.
An example of treatment would be a review of your file by other physicians involved in your care.
An example of payment would be to provide a description of services performed for billing.
An example of operations would be to allow our staff access to your records for authorization for services, or leaving a message regarding scheduling at the contact number you have provided to our office..

Business Associates: There are some services provided in our organization through agreements with business associates. Examples include physician services in the radiology department, certain laboratory tests, services provided by a copy service when making copies of your health record and services provided by an outside transcription service. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.
Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Public Health: As required by law, we may disclose your health information to the institution or agents thereof, health information necessary for your health and the health and safety of other individuals.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

☐ No one is authorized to pick-up or discuss my medical information other than myself. To include x-ray results, scheduling surgery, appointments, etc.

Patient Signature:_____Date:_____

Print Name:_____If signing as parent or guardian, Patient Name:_____

Dr. Sweet Patient History Information

Patient Name: _____ **Todays Date**: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____ Height: _____ Weight: _____

How did you hear about Dr. Sweet:

__ Sweetortho.com (his website) __ Oceanorthopedics.com (Ocean's website) __ Google __ Facebook __ Yelp

__ Zocdoc __ Twitter __ Linkedin __ You Tube __ Friend/Relative _____

__ Physical Therapist _____ Primary Care Physician _____

__ Other Physician _____ __ Other _____

Dominant Hand: RIGHT LEFT

Please describe your problem: _____

Date of onset? _____ Is your problem due to an injury? YES NO

If injury, how did it happen? _____

How did the pain start? _____

DESCRIBE YOUR SYMPTOMS: _____

Is your pain Sharp, Dull or Other _____

Does the pain radiate? YES NO If so, where? _____

Do you have weakness? YES NO

Do you notice any of the following?

Swelling	Catching	Locking Tingling
Instability	Numbness	Other: _____

Please CIRCLE the number that best describes your pain on a scale of 1-10:

⟹ 1 2 3 4 5 6 7 8 9 10 1 = hardly any pain 10 = terrible pain

What activities make your pain worse?

RUNNING	SITTING	REACHING FOWARD	REACHING OVERHEAD
WALKING	STANDING		
JUMPING	LIFTING OBJECTS	OTHER_____	

What activities make the pain better? _____

What previous treatments have you tried? P/T Brace Injection Surgery Medications _____
Other _____

Are you claustrophobic (uncomfortable in enclosed areas)? YES NO

Do you have any retained metal (e.g., metal joints, pins, pacemaker) YES NO If yes,
WHERE_____

Do you smoke? YES NO

If yes, how long? _____ How many packs per day? _____

Do you use alcohol in any form? YES NO If yes, how long? _____ How much? _____

PLEASE ALSO COMPLETE THE OTHER SIDE OF FORM⏩

FAMILY PHYSICIAN _____

CARDIOLOGIST _____ **Pharmacy** _____

PLEASE LIST MAJOR MEDICAL ILLNESSES (e.g., High Blood Pressure, Heart Disease, diabetes, cancer, etc.).

Illness	Date Diagnosed

PLEASE LIST PREVIOUS OPERATIONS OR HOSPITALIZATIONS AND DATES,

Type of Operation or Hospitalization	Date

PLEASE LIST ALL MEDICATIONS AND DOSAGES TAKEN WITHIN THE LAST YEAR, INCLUDING NONPRESCRIPTION MEDICATIONS SUCH AS ASPIRIN AND VITAMINS.

Medication & Dosage	Frequency

LIST ALLERGIES TO MEDICATIONS:_____

Please list any **FAMILY HEALTH PROBLEMS**, such as cancer; heart, lung or kidney disease; stroke; hypertension; or allergies?_____

PERSONAL HEALTH HISTORY
(Please circle all that apply)

General Constitutional	Recent weight gain, Recent weight loss, Fever, Chills, Sweats
Eyes	Blurry vision, Double vision
Ear, Nose, Mouth, Throat	Hearing loss, Dizziness, Tooth or gum disease
Cardiovascular	Chest pain, Heart attack, Skipping heartbeat, High blood pressure, Shortness of breath, Heart murmur, Heart disease
Respiratory	Pneumonia, Chronic cough, Tuberculosis, Coughing up blood, Wheezing, Asthma
Gastrointestinal	Heartburn, Diarrhea, Black stools, Bloody stools, Ulcers, Yellow skin, Constipation
Genitourinary	Frequent urination, Difficulty urinating, Bloody urine WOMEN: Excessive bleeding during periods, Bleeding between periods Pregnancies MEN: Difficulty starting urinary stream, Difficulty maintaining erections
Musculoskeletal	Muscle pain, Joint pain or swelling, Arthritis
Skin	Rashes, Ulcers, Infection
Neurologic	Numbness, Tingling, Weakness, Seizures, Loss of coordination
Psychiatric	Emotional problems, Anxiety, Depression, Mood swings
Endocrine	Diabetes, Thyroid or other glandular problems
Hematological	Anemia, Easy bruising, Easy bleeding

_____ _____

Date: Patient Signature Physician Initials - Reviewed