☐ SERGE KASKA, MD ☐ ERIN FARRELLY, MD ☐ HANNAH KIRBY, MD

PATIENT REGISTRATION

PATIENT INFORMATION: PLEASE PRINT

First Name: _____ **Last Name:** _____ **MI:** _____

Date Of Birth: _____ **Age:** _____ **SSN:** _____ **Gender:** ☐ Male ☐ Female

Ethnicity Of Patient: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Unknown ☐ Declined To Answer

Race Of Patient: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown ☐ Declined To Answer

Marital Status: ☐ Registered Domestic Partner ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Spouse's Name: _____ **Spouse's Date Of Birth:** _____

Preferred Language Of Patient: ☐ English ☐ Spanish ☐ Other _____

Email Address: _____

Home Address: _____

City, State & Zip Code: _____

Preferred Contact Phone: (_____) _____ (Check One) ☐ Home ☐ Work ☐ Mobile

Alternate Contact Phone: (_____) _____ (Check One) ☐ Home ☐ Work ☐ Mobile

Occupation: _____

Employment/Student Status: ☐ Full Time Employed ☐ Part Time Employed ☐ Unemployed ☐ Retired
☐ Part Time Student ☐ Full Time Student ☐ Not A Student

Employer Name: _____ **Employer Phone:** _____

Emergency Contact Name: _____ **Relationship To Patient:** _____

Emergency Contact Phone: (____) _____

Primary Care Physician: _____ **Referring Physician:** _____

FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT FROM PATIENT):

Full Name: _____ **Address:** _____

City, State & Zip Code: _____

Date Of Birth: _____ **Social Security Number:** _____

Home Phone: (____) _____ **Work Phone:** (____) _____ **Mobile Phone :** (____) _____

Relationship To The Patient: (Check One) Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

KASKA orthopaedics
277 Rancheros Drive Suite 101, San Marcos, CA 92069 | p. 760.750.1902 f. 760.750.1906

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PATIENT REGISTRATION

Name: _____ **Date of birth:** _____

ACCOUNT TYPE: ☐ Cash/Self-Pay ☐ Insurance ☐ Lien ☐ Workman's Comp

INSURANCE COMPANY INFORMATION:

Primary Insurance Company Name: _____

Policy Holder Name: _____ **Date Of Birth:** _____

Relationship To The Patient: (Check One) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Secondary Insurance Company Name: _____

Policy Holder Name: _____ **Date Of Birth:** _____

Relationship To The Patient: (Check One) ☐Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to the above physician. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature: _____ **Date:** _____

Medicare Patients Only:

Do You Currently Reside In A Skilled Nursing Facility? ☐ Yes ☐No

In Medicare cases, the above physician, agrees to accept the charge determination of Medicare as the full charge, and the patient isresponsible only for deductible, coinsurance and non-covered services. Coinsuranceand the deductibles are based upon the charge determination of Medicare.

Signature: _____ **Date:** _____

In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

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PATIENT FINANCIAL AGREEMENT

Your Responsibilities and Acknowledgments:

The patient or the patient's Legal Representative* is responsible for the following:

- Determine if your treating physician is a participant in your medical insurance plan.
- Know what services are covered by your medical insurance. The cost of any service NOT covered by insurance is the responsibility of the patient, and will be billed in full to the patient.
- Ensure we have your correct medical insurance and address information. Our office will bill your insurance for services rendered.
- Pay your deductible and/or co-payment at the time of the visit, before services are rendered. If co-payment is not paid at that time, our office may charge an additional administrative fee of $20.
- Our office will bill the patient for balances due from co-insurance, deductibles, or for non-covered services.
- All outstanding charges shall be paid within the initial billing cycle - 30 days.
- We request at least 24 hour notice if you must cancel or reschedule an appointment.
- A Self-Pay/Cash Patient is one who does not have medical insurance that covers the treating physician. Self-Pay/Cash Patients are expected to pay in-full at the time services are rendered, unless other arrangements have been made. Please contact our office to make prior arrangements for payment.
- Payments may be made via VISA, MasterCard, Cashier's Check or Cash. Personal checks are **not** accepted.
- Overdue accounts shall be sent to a collections agency or may be subject to legal action. Relevant personal and account information will be released in this course of action. The costs of such action shall be added to the patient's outstanding balance.

*Legal Representative is defined as the parent of a minor child or person named in a legal document such as a Power of Attorney or Guardianship. Please provide us a copy of the pertinent legal document.

I agree to these terms and acknowledge that this is a binding agreement.

_____

Print Name of Patient or Patient's Legal Representative

_____

Signature of Patient or Patient's Legal Representative

_____

If Legal Representative, State Relationship to Patient

_____

Date

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HIPAA - RELEASE OF PROTECTED HEALTH INFORMATION

TO BE COMPLETED BY PATIENT

Please list the family members, significant others, or other persons, if any, whom may have access to your medical records and whom we may inform about your general medical condition and your diagnosis. This may also include treatment plan, prognosis, payment information and health care options:

Name:_____ **Relationship:**_____ **Phone:**(___)_____

Name:_____ **Relationship:**_____ **Phone:**(___)_____

Name:_____ **Relationship:**_____ **Phone:**(___)_____

Please print the telephone number where you want to receive calls about your appointments, labs, and x-ray results or other health care information. This may include surgery scheduling information, and post-operative instructions:

Home :(___) _____ **Mobile :**(___) _____

(I am fully aware that a mobile phone is not a secure and private line)

Do you wish to communicate with our office via email? ☐**Yes** ☐**No**

Email Address_____
(Consider e-mail like a postcard that can be viewed by unintended persons.)

I have requested to correspond using email. I understand that there is no guarantee of confidentiality using email. **Initial:** _____

May confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?
☐**Yes** ☐**No**

_____ _____
Signature of Patient or Legal Guardian **Date**

NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.

PRIVACY PRACTICES ACKNOWLEDGEMENT

NOTE: A copy of our office Privacy Policy is available upon request.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____
Please Print Patient Name **Date of Birth**

_____ _____
Signature of Patient or Legal Guardian **Date**

If not signed by the patient, please indicate relationship:
☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Name of Representative:_____

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MEDICAL HISTORY FORM

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: _____ **Preferred Name (If Different):** _____

Height: _____ **Weight:**_____ **Dominant Hand:**□R □L

REASON FOR VISIT:

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
L R	L R	L R	L R	L R	L R	L R	L R		

□**Numbness**□**Pain**□**Weakness**□**Swelling**□**Stiffness**□**Other:** _____

How Long Ago Did It Start?:_____**Days**_____**Weeks**_____**Months**_____**Years**

Have You Had A Problem Like This Before?:□YN

DESCRIPTION OF PROBLEM:

□**No Injury:**□Gradual Onset□ Sudden Onset□**Injury:**□Accident Sports Date Of Injury: _____

□**Injury At Work:**Date Of Injury: _____ □**Auto Accident:**Date Of Accident: _____

Please Describe Problem Briefly: _____

_____

TREATMENTS FOR PROBLEM:

Have You Had Any Of These Treatments?:□Medication □Injection □Brace □Physical Therapy □Crutches

Were You Seen In The E.R. For This Problem?:□Y □N Where?_____ Date: _____

What Tests Have You Had For This Problem?:□X-Rays □MRI□CT Scan □Bone Scan □Nerve Test□None

Have You Ever Had Surgery For A Problem In This Same Area?:□Y□ N

Procedure: _____ Surgeon: _____ Date: _____

PAST MEDICAL HISTORY:

List Current Medical Problems:_____

_____

_____

_____

List Current Medications And Dosage:□None See Patient Provided Medication List □ See List Below:

MEDICATION NAME	DOSAGE	FREQUENCY

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MEDICAL HISTORY FORM

Preferred Pharmacy: Name: _____

Street/City: _____ Phone: (___) _____

Allergies (Medication Or Latex): ☐ None _____

_____

_____

Are You Diabetic? ☐ Y ☐ N **If Yes, Treatment:** ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

Are You Taking, Or Have You Ever Taken, Blood Thinners?: ☐ Y ☐ N **If Yes, Which One:** _____

PAST SURGICAL HISTORY OR HOSPITALIZATIONS:

Have You Ever Had Surgery: ☐ Y N **If Yes, Please List:** _____

_____

_____

_____

Have You Or A Family Member Ever Had A Reaction To Anesthesia?: ☐ Y ☐ N **If Yes, Please Explain:** _____

_____

Have You Ever Had (Check All That Apply, Or None, If None Apply):

☐ Heart Attack (Yr ___) ☐ Stroke (Yr ___) ☐ Blood Clots (Yr ___) ☐ Heart Failure ☐ High Blood Pressure

☐ Ankle Swelling ☐ Kidney Failure

☐ Stomach Ache While Taking Anti-Inflammatory Medication (Caused By ☐ Advil ☐ Aleve ☐ Other: _____)

☐ Cancer (Location) _____ ☐ None Apply

FAMILY AND SOCIAL HISTORY:

Have Any Direct Relatives Had Any Of The Following Disorders? If So, Which Relative?:

☐ Diabetes: _____ ☐ High Blood Pressure: _____

☐ Cancer: _____ ☐ Rheumatoid Arthritis: _____

☐ None Apply

Alcohol Use?: ☐ Y ☐ N **If Yes, How Often?:** ☐ Rarely ☐ Socially ☐ _____ Drinks Daily ☐ _____ Drinks Per Week

☐ Recovered Alcoholic

Recreational Drugs?: ☐ Y ☐ N **If Yes, How Often?:** _____ **Type:** _____

Do You Currently Use Tobacco?: ☐ Y ☐ N **If Yes, Packs Per Day:** _____

Are You A Former Smoker?: ☐ Y ☐ N **How Long Did You Smoke For?:** _____ **When Did You Quit?:** _____

Exercise/Sports Activities: _____

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NAME : _____ DATE : _____ / _____ / _____

REVIEW OF SYSTEMS

Have you had, or do you have, any of the following illnesses or diseases? Check all that apply.

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Gallstones
- ☐ Convulsion
- ☐ Phlebitis/Leg Clot
- ☐ Heart Attack
- ☐ Jaundice
- ☐ Concussion
- ☐ Pulmonary Embolus
- ☐ Heart Failure
- ☐ Liver Cirrhosis
- ☐ Depression
- ☐ Blood Transfusions
- ☐ Heart Murmur
- ☐ Bowel Obstruction
- ☐ Anxiety
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Migraine/Tension Headaches
- ☐ Blood Clot
- ☐ Emphysema
- ☐ Ulcer
- ☐ Stroke
- ☐ Poor Blood Flow
- ☐ Tuberculosis
- ☐ Hernia
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Bleeding Problem
- ☐ Cataracts
- ☐ Post-Traumatic Stress Disorder
- ☐ Bronchitis
- ☐ Kidney Disease
- ☐ **NONE APPLY**

Do you have any of the following complaints? Check all that apply.

CONSTITUTIONAL

- ☐ Weight change
- ☐ Fever or chills

SKIN

- ☐ Rashes / Sores

EYES & VISION

- ☐ Loss or change of vision
- ☐ Eye pain or redness
- ☐ Excessive watering
- ☐ Double vision

EARS & HEARING

- ☐ Loss of hearing
- ☐ Buzzing or noises in ear
- ☐ Ear infection / drainage

NOSE & THROAT

- ☐ Hoarseness
- ☐ Blocked nasal passages
- ☐ Nosebleeds
- ☐ Frequent running nose
- ☐ Difficulty swallowing

RESPIRATORY

- ☐ Wheezing
- ☐ Bloody sputum
- ☐ Excessive cough
- ☐ Night Sweats
- ☐ Shortness of breath

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Abnormal or fast heartbeat
- ☐ Calf cramps with walking
- ☐ Varicose veins
- ☐ Cold sensitivity of toes & fingers
- ☐ Frequent or marked swelling of ankles & feet
- ☐ Other_____

GASTROINTESTINAL

- ☐ Digestion difficulties
- ☐ Frequent nausea or vomiting
- ☐ Lack or loss of appetite
- ☐ Stomach or abdominal pain
- ☐ Frequent loose bowel or recurring diarrhea
- ☐ Bloody stool, black stool
- ☐ Other_____

GENITOURINARY

- ☐ Urinary incontinence
- ☐ Bloody urine
- ☐ Painful urination
- ☐ Flank pain
- ☐ Urination urgency
- ☐ Difficulty starting or passing urine
- ☐ Other_____

GENITOURINARY (MALE)

- ☐ Penile pain
- ☐ Abnormality of testicles
- ☐ Scrotal swelling
- ☐ Infection or sores
- ☐ Prostatitis
- ☐ Penile discharge
- ☐ Difficulty with sexual function

GENITOURINARY (FEMALE)

- ☐ Breast discharge, swelling, lumps
- ☐ Vaginal pain
- ☐ Known uterine fibroids / tumors
- ☐ Infections
- ☐ Abnormal or painful menstrual flow
- ☐ Infertility or difficulty conceiving
- ☐ Change in body hair distribution
- ☐ Difficulty with sexual function

NEUROLOGIC

- ☐ Numbness
- ☐ Weakness
- ☐ Seizures
- ☐ Other_____

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Other_____

☐ **NONE APPLY**

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