

I. Consent and Authorization for Release of Information

1. Release of Information. I consent to the release and use by Desert Orthopedics (referred to as "DO") of medical and other information about me to the extent permitted by law to the following:

- To a health care provider being advised or consulted in connection with my treatment or care;
- To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
- To a person or organization in connection with DO's health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.

2. Revocation. I understand that this consent shall continue until I revoke it, which I may do at anytime by giving written notice to DO.

II. Payment Authorization

1. Payment Responsibility. I agree to pay for all services furnished to me by DO, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by DO's contract with my health plan or applicable law. I also agree to pay or reimburse DO for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees.

2. Payment Authorization. I authorize DO to directly bill my health plan or third-party payor for services rendered to me by or on behalf of DO, but acknowledge that DO is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third-party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to DO for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to DO directly on my behalf by my Medigap insurer. I understand and agree that DO is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

3. Statement to permit payment for Medicare Benefits to DO. If I am entitled to Medicare Benefits, I request payment of authorized Medicare benefits to me, or on my behalf to DO, for any services furnished to me by or in DO, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

III. Notice of Privacy Practices

1. Confidentiality. It is the policy of DO to protect the privacy and confidentiality of patients' medical information.

2. Notice of Privacy Practice. DO's Notice of Privacy Practices explains how DO may use and disclose my medical information. It also explains my rights regarding this kind of information. DO may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. DO's Notice of Privacy Practices is available at the Reception Desk.

3. Acknowledgment of Receipt. I acknowledge that I have received DO's Notice of Privacy Practices.

Signature of Patient (if applicable): _____ Date: _____

Signature of Legal Guardian (if applicable): _____ Date: _____



Name _____ Age _____ Height _____ Weight _____

Who is your primary care physician? _____ Who referred you? _____

Please describe the problem that brings you here today: _____

When and how did the problem begin? _____

Did you have a specific injury? Yes No If yes, what occurred? _____

If the injury is work-related, did you file a Workers Compensation Claim? Yes No If yes, list claim number: _____

Are you currently working? Yes No If no, how long have you been off? _____

Is there any litigation or a disability suit involved in your case? _____

Do you have a lawyer involved with this problem? Yes No If yes, lawyer's name: _____

What symptom(s) best describes your problem: Pain Weakness Numbness Swelling Other _____

Do you now have any associated problems? Numbness Tingling Weakness Increased pain with coughing, sneezing or straining

If you have pain, please describe the pain:

Sharp Dull Throbbing

Aching Burning Stabbing

Heavy Electric shock

Other _____

What is the duration of the pain?

Constant Intermittent (on and off)

Other _____

What makes your symptoms better?

What makes your symptoms worse?

TREATMENT HISTORY

Have you seen or are you being seen by a physician for this problem? Y N

If yes, who? _____

Have you tried any of the following to help your symptoms?

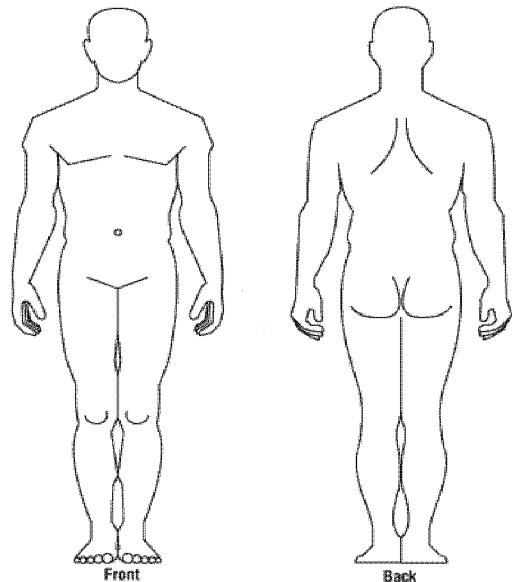
TYPE OF TREATMENT (check all that apply)		DID IT HELP?	
		YES	NO
Medications	<input type="checkbox"/>		
Injections	<input type="checkbox"/>		
Physical/Occupational Therapy	<input type="checkbox"/>		
Acupuncture	<input type="checkbox"/>		
Chiropractic Treatment/ Massage	<input type="checkbox"/>		
Surgery	<input type="checkbox"/>		
Implanted Neurostimulator or Pump	<input type="checkbox"/>		

Circle the number corresponding to the intensity of your pain:

Back/Neck: No Pain = 0 1 2 3 4 5 6 7 8 9 10 =Worst pain

Leg/Arm: No Pain = 0 1 2 3 4 5 6 7 8 9 10 =Worst pain

Mark the areas of your body where you feel pain on the diagram:



What studies have you had for this problem?

TYPE OF STUDY (check all that apply)	
X-rays/ CT Scan	<input type="checkbox"/>
MRI	<input type="checkbox"/>
Bone Scan	<input type="checkbox"/>
Nerve Study (EMG)	<input type="checkbox"/>

MEDICATIONS

List all current medications. Include dosages & reason:

ALLERGIES to medication: _____ None

MEDICAL HISTORY

Have you ever had: (circle)

Excessive bleeding	Blood clot /DVT	Hepatitis	Osteoarthritis	Alcohol addiction
Heart stent	Stroke	Ulcer	Rheumatoid arthritis	Drug addiction
Heart attack	Fibromyalgia	Diabetes	Gout	Reaction to anesthesia
Irregular heart beat	Edema/Leg swelling	Kidney disease	Sleep apnea	Blood thinners/Aspirin
High blood pressure	Claudication/Calf pain	Thyroid problem	Muscle disease	

Cancer: (Type) _____ None

Please list other medical problems, past and present:

SURGICAL HISTORY

Please list surgeries you have had:

_____	Date _____	Surgeon _____
_____	Date _____	Surgeon _____
_____	Date _____	Surgeon _____
_____	Date _____	Surgeon _____

No previous surgeries

REVIEW OF SYSTEMS

Do you experience: (circle)

Weight loss	Shortness of breath	Heartburn	Anxiety
Fever	Chest pain	Abdominal pain	Depression
Rash	Ankle swelling	Blood in stool	Sleep problems
Easy bruising/bleeding	Seizures	Blood in urine	<input type="checkbox"/> None
	Numbness	Urinary incontinence	

FAMILY HISTORY

Indicate all medical conditions experienced by any parent, sibling, or child: (circle and note family member)

Heart Disease _____	Lupus _____	Rheumatoid Arthritis _____
Stroke _____	Fibromyalgia _____	Scoliosis _____
Diabetes _____	Alcoholism _____	Other _____

Cancer (type) _____ None

SOCIAL HISTORY

Marital Status: S M D W Number of children? _____ Occupation/Employer _____

Tobacco use: Yes / No _____ packs per day _____ years _____ date quit

Alcohol use: Yes / No _____ drinks per week Marijuana use: Yes / No _____ per week

Fitness/Sports/Athletic activities: _____

SIGNATURE _____ DATE _____