ADVANCED ORTHOPAEDICS

Demographics

(All information MUST be completed in order to bill your insurance company)

Patient's Last Name:_____ First Name:_____ M.I._____

Date of Birth:_____ Social Security Number:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone #: _____ Work #: _____ Cell #: _____

Email _____@_____

Preferred Method of Contact: ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

Race: ❑ American Indian/Alaskan National ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑ White ❑ Patient Declined

Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino ❑ Declined

Sex: ❑ Male ❑ Female

Emergency Contact:_____Relationship:_____Phone #:_____

Occupation:_____ Employer:_____

Date of Injury: _____ Employer Phone: _____ Employer Fax: _____

WC Insurance: _____ Claim Number: _____

Phone: _____ Fax: _____

Referring Physician:_____ Phone #:_____

Attorney Information

Attorney Name: _____

Attorney Phone: _____ Attorney Fax: _____

**I understand that I am liable for expenses incurred which are not covered under my medical plan and that all co-payments, deductibles and/or non-covered services are to be paid in full at the time of the service. I hereby authorize the release of any information to my insurance company necessary to process the claims. I hereby authorize my insurance company to make payments directly to the physician. _____ (Initials)

Signature:_____ Date:_____

Print Name:_____

ADVANCED ORTHOPAEDICS

Financial Agreement for Workers' Compensation

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available to you for your work related injury or illness.

Payment Arrangements

Because you are being treated for a work-related condition, we would like for you to understand how your case will be handled by our office. The first thing that you need to know is that your employer or your employer's insurance carrier, by law, is financially responsible for payment of all treatment charges which are a result of your industrial injury or condition. You are entitled to receive all necessary care and treatment which restores your health to a pre-injury status or to a permanent and stationary condition.

If however, upon investigation, it is determined by your employer or their Workers' Compensation carrier that your injuries are not industrially caused or related, you will be responsible for the payment of all treatment charges previously incurred, as well as all future charges.

Notification of Employer

When you have suffered a work-related injury or illness, the law requires that you notify your employer immediately, no later than 30 days from knowledge of your injury. If you do not report your injury as required, you may lose your benefits and you may be responsible to personally pay for the charges incurred in our office.

Pre-existing Condition or Symptoms

If it has been determined, upon my evaluation that you are currently experiencing symptoms or problems that are unrelated to your industrial injury, you will be responsible for payment of those treatment charges, as your employer or their Workers' Compensation carrier will not be responsible for treatment to a non-industrial condition. We will be happy to file a separate claim to your private insurance policy if applicable.

Your Responsibilities

This office specializes in the treatment of Workers' Compensation patients, so it is very important for you to follow our recommendation and to keep your scheduled appointments with this office in order to achieve maximum benefit to your condition. If you choose not to receive the care that is recommended for the treatment of your condition, we will notify your Workers' Compensation carrier and your case will be closed.

Termination of Care

When your condition has reached "pre-injury status," or is determined to be "permanent and stationary," we will notify you and your Workers' Compensation insurance carrier, and close your Workers' Compensation claim in our office.

We thank you for the opportunity to serve you and welcome any questions that you may have concerning your case.

I have read and understand this financial arrangement and realize that all fees regardless of the insurance coverage are ultimately my responsibility.

Patient Signature or Responsible Party:_____ Date:_____

Print Name:_____

ADVANCED ORTHOPAEDICS
6140 Camino Verde Dr. Suite L | San Jose, CA 95119
3800 J st suite 220 | Sacramento, CA 95128
Phone: (408) 224-1267 Fax: (408) 926-6858

Consent to Release Records

Patient Name: _____ Date of Birth: _____

Reason for transfer/copy _____

_____

I hereby authorize as needed and request Advanced Orthopaedics to (family member, PCP, attorney, etc.)

- ○ Release Information to Or ○ Obtain Information From

_____

Information To Be Disclosed

- ○ Medical Records from (Date) _____ To (Date) _____
- ○ Entire medical history, including patient history, office notes, test results, radiology studies, films, referrals, etc.
- ○ Other _____

_____

I understand that:

- ○ Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- ○ I can cancel this authorization at any time by writing to Advanced Orthopaedics. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- ○ Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

_____ _____

Patient/Parent/Guardian/Legal Representative Signature Date

_____

Printed Name & relationship to patient, if applicable

ADVANCED ORTHOPAEDICS

Policy on Narcotic Pain Medication

Unfortunately, it is very likely that all patients that seek help from an orthopedic surgeon have some degree of pain. One of the goals of seeking help is pain relief besides restoration of function. Since the majority of pain medications are narcotics or substances closely related to narcotics every medical office needs a policy as these substances are controlled by law enforcement. The reason for this is the potential for addiction and abuse and all its associated problems.

- **NO** narcotics or Anxiety medications will be called in under ANY circumstances.
- Narcotics **CANNOT** be called into a pharmacy as they are controlled substances.
- Since narcotic medications need to be documented and controlled, **a prescription for the medication(s) requires an office visit** minimum every 3 months or as directed by the provider.
- **NO** automatic refills will be given for narcotics.
- **NO** calls regarding narcotics will be answered after hours or on weekends.
- Please take ALL medications as directed- **NO EARLY REFILLS OF ANY MEDICATIONS WILL BE AUTHORIZED.**
- **NO** prescriptions will be replaced for any of the following reasons:
    1. "My dog/cat/bird ate my medication"
    2. "My sister/mother/brother/child/roommate/prison buddy stole them"
    3. "I left them in my pants and accidently washed them in the washing machine"
    4. "I threw/dropped them in the toilet"
    5. "They were in my car which was stolen/impounded/burned down"
    6. "I moved and can't find them"
    7. "I am leaving out of town for an extended period of time and need additional medication"

Preferred Pharmacy

Pharmacy name:

Phone Number & Address: _____

_____

1. If it is discovered that you are receiving narcotics from another physician, that physician will be notified, we will immediately discontinue your medication and notify your pharmacy.
2. If there is acute pain for a new condition for which the patient seeks treatment elsewhere, our practice must be called to let us know of the other physicians prescribing, and at that time we may adjust your pain medication.
3. By signing this policy you agree to solely receive narcotic prescriptions from my office.

Please acknowledge that you have read and understand the policy by signing this agreement.

**No medications will be prescribed if this policy is not signed.

Patient Signature or Responsibly Party:_____ Date:_____

Print Name:_____

ADVANCED ORTHOPAEDICS

6140 Camino Verde Drive Suite L San Jose, CA 95119
3800 J st Suite 220 Sacramento, CA 95128

Blood Pressure: /

Health Questionnaire

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Marital Status: **Single** **Married** **Divorced** **Other** **(Circle one)** Number of Dependents: _____

Are you **right** or **left** handed? **(Circle one)** Male_____ Female_____

Who is your Primary Care Physician? _____Phone:_____

Who referred you to Advanced Orthopaedics?
Friend ☐ Insurance Website ☐ Yelp ☐ Google ☐
Doctor _____ Hospital _____

Which Body Part would you like to discuss (**circle box**) Circle one or both (**Left** or **Right**)

Neck	**Pelvis**	**Upper Arm**	**Wrist**	**Thumb**	**Shin**
Mid Back	**Hip**	**Elbow**	**Hand**	**Thigh**	**Ankle**
Low Back	**Shoulder**	**Forearm**	**Finger**	**Knee**	**Foot**

When did the current problem start: _____

How did it start? (**Accident, Sudden onset, Just started hurting, Slow onset etc…)**_____

_____

What symptoms do you currently have? (**Please, circle all that apply)**

Pain **Instability** **Locking** **Clicking or Popping** **Numbness** **Swelling** **Bruising**

Describe the pain (**Faint, Sharp, Dull, Tingling, Burning**) _____

Describe the severity (**Minimal, Mild, Moderate, Severe**) _____

Describe the timing (**Occasional, Intermittent, Constant**) _____

Is this problem work related? _____

Have you had x-rays? _____Which Body Part?__ _____ Where was it taken? _____

Have you had an MRI? _____Which Body Part? _____ Where was it taken? _____

Please, indicate with an X if you have had any of the following treatment for your current medical condition?

Shots **Physical Therapy** **Chiropractor** **Surgery** **Medications**

Are you currently taking any medication for other medical issues? If so, please list:_____

_____

Have you had prior surgeries? _____ If so, please list date, procedure and type of anesthetic:

Date: Procedure: Anesthetic:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any other medical conditions?

High Blood Pressure		High Cholesterol	
Arthritis		Rheumatoid Arthritis	
Psoriasis		Hepatitis	
Lupus		Multiple Sclerosis	
Diabetes		Vascular Disease	
Stomach Ulcer, Reflux		Heart Disease	
Emphysema, Asthma		Depression	
Blood clots		Bladder Problems	
Infections		Cancer	

Others: _____

Do you have allergies to any medication? _____

Do you have allergies to latex? _____

Are there any medical conditions in your immediate family (**please describe below**)

Age: Mother:_____ Father: _____

High Cholesterol
High Blood Pressure
Heart Disease

Stroke
Blood Clots
Diabetes

Cancer
Arthritis
Autoimmune Disease
Hereditary Disease

Others: _____

Are you taking any recreational drugs? Yes _____ No _____

If so, please list: _____

Do you smoke? _____ How Much? Daily ___ Weekly _____ Monthly _____

Do you drink Alcohol? _____ How Much? Daily ___ Weekly _____ Monthly _____

Are you retired? _____ Are you disabled? Temporary_____ Permanent _____ No_____

Do you work? _____ ___ Part-Time_____ Full-Time:_____

What is your profession? _____

Are you currently suffering from any of the following symptoms?

Change in weight		Fever		Night sweats	
Difficulty Sleeping		Lumps		Rash	
Change in moles		Problems swallowing		Wheezing	
Change in vision		Coughing		Fainting	
Problems hearing		Palpitations		Red Urine	
Nose bleeds		Urgency to Urinate		Cramps	
Shortness of breath		Vomiting		Black stools	
Chest pain		Heartburn		Varicose Veins	
Urine burning		Blood clots		Muscle cramps	
Nausea		Muscle Pain		Weakness	
Diarrhea		Back Pain		Memory Loss	
Swollen ankles		Change in memory		Change in speech	
Joint Pain		Depression			
Stiffness		Anxiety			

Signature: _____ Date: _____

ADVANCED ORTHOPAEDICS

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS	**PLEASE DO NOT USE THIS COLUMN**
2. EMPLOYER NAME	**Case No.**
3. Address No. and Street City Zip	**Industry**
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)	**County**
5. PATIENT NAME (first name, middle initial, last name) / 6. Sex ☐Male ☐Female / 7. Date of Birth Mo. Day Yr.	**Age**
8. Address: No. and Street City Zip / 9. Telephone Number ( )	**Hazard**
10. Occupation (Specific job title) / 11. Social Security Number	**Disease**
12. Injured at: No. and Street City County	**Hospitalization**
13. Date and hour of injury or onset of illness Mo. Day Yr. Hour a.m. p.m. / 14. Date last worked Mo. Day Yr.	**Occupation**
15. Date and hour of first examination or treatment Mo. Day Yr. Hour a.m. p.m. / 16. Have you (or your office) previously treated patient? ☐Yes ☐No	**Return Date/Code**

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code. 17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED. (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐Yes ☐No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐Yes ☐No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐Yes ☐No If "yes", please explain.

23. TREATMENT RENDERED (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐Yes ☐No
If "no", date when patient can return to: Regular work ____/____/____
Modified work ____/____/____ Specify restrictions _____

Doctor's Signature _____ CA License Number _____A54508_____

Doctor Name and Degree (please type) ____Dr. Christian Foglar, M.D_____ IRS Number ____208317738_____

Address ____6140 Camino Verde Drive, Suite L, San Jose, CA 95119_____ Telephone Number (_408_)_224-1267_____

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.