Andersen ORTHOPEDICS
A Professional Corporation

HEALTH QUESTIONNAIRE

PERSONAL INFORMATION

NAME						**TODAY'S DATE**			
BIRTHDATE		**AGE**		**HEIGHT**		**WEIGHT**		**BMI**	
ADDRESS						**PHONE**			
CITY		**STATE**				**ZIP CODE**			

ALLERGIES/SENSITIVITIES

Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle one			If "YES" Please list specific food or drug and type of reaction (example hives):
Penicillin or other antibiotics	☐No	☐Yes	☐ Don't Know	
Morphine , Codeine, Demerol or other narcotics	☐No	☐Yes	☐ Don't Know	
Aspirin, Empirin or other pain remedies	☐No	☐Yes	☐ Don't Know	
Sulfa drugs	☐No	☐Yes	☐ Don't Know	
Adhesive tapes	☐No	☐Yes	☐ Don't Know	
Iodine or merthiolate/ Shell fish	☐No	☐Yes	☐ Don't Know	
Any other drug or medication	☐No	☐Yes	☐ Don't Know	

MEDICAL CONDITIONS THAT I HAVE: (check all that apply)

☐ Diabetes: (controlled by)
- ☐ Insulin ☐ Diet ☐ Oral meds

☐ High cholesterol
☐ Kidney problems
☐ Osteoporosis/ brittle bones
☐ High blood pressure
☐ **No Known Conditions**

☐ Heart problems
☐ Heart attack
☐ Blood clot formation/DVT/PE
☐ HIV/AIDS
☐ Stroke/CVA
☐ MRSA/Resistant Bacteria Infection

☐ Stomach ulcers/gastritis
☐ Stomach reflux/GERD
☐ Thyroid problems
☐ Cancer of:
☐ Neuropathy
☐ Sleep Apnea
☐ Other: _____

IMMUNIZATIONS

	Date Administered		Date Administered
Influenza ☐No ☐Yes		Pneumonia ☐No ☐Yes	

PREVIOUS SURGERIES/PROCEDURES

Date	Name (what was done)	Hospital/Surgery Center	Surgeon

MEDICATIONS

Name	Dosage	How Often	Prescribing Doctor	Why

FAMILY MEDICAL HISTORY

Medical Condition:	Family member(s):	Medical Condition:	Family member(s):
☐ Diabetes		☐ Cancer of:	
☐ High blood pressure		☐ Stroke/CVA	
☐ High cholesterol		☐ Bleeding problems	
☐ Heart problems		☐ Blood clot formation/DVT	
☐ Asthma		☐ Other:	
☐ Anesthesia problems		☐ Other:	

SOCIAL HISTORY

Circle One: Single Married Separated Divorced Widowed Domestic Partner

Alcohol use: Beer Wine Hard Alcohol	**Tobacco use: Cigarettes Cigar Chew**	**Recreational drug use:**
☐ None/rarely	☐ I don't smoke	☐ None
☐ 1-2 drinks/week	☐ I quit in_____after smoking _____packs/day for _____ years	☐ Occasionally
☐ 1-2 drinks/day		☐ Regularly
☐ Three or more drinks/day	☐ ½ to 1 pack/day	☐ Drugs I commonly use:
☐ Difficulty with heaving alcohol use in the past	☐ 2 or more packs/day	

SYSTEMIC REVIEW: PLEASE ANSWER YES OR NO TO ALL QUESTIONS BELOW

CONSTITUTIONAL:	YES	NO	EYES	YES	NO	RESPIRATORY	YES	NO
Chills			Blurry vision			Asthma		
Decline in Health			Cataracts			Cough		
Fatigue			Discharge			Wheezing		
Fever			Double Vision			Bronchitis		
Weakness			Excessive Tearing			Coughing Blood		
Weight Gain			Eye Pain			Pain		
Weight Loss			Eyeglass Use			Pleurisy		
HEAD			Glaucoma			Positive TB Test		
Dizziness			Infections			Recent Chest X-Ray		
Fainting			Pain with Light			Short of Breath		
Head Injury			Recent injury			Sputum		
Headaches			Redness			Tuberculosis		
Pain			Unusual Sensations					
Sweats			Vision Loss					

CARDIOVASCULAR	YES	NO	GASTROINTESTINAL	YES	NO	NEUROLOGICAL	YES	NO
Chest Pain			Abdominal Pain			Loss of Consciousness		
Palpitations			Constipation			Blackouts		
Varicose Veins			Diarrhea			Dizziness		
Extremity(s) Cool			Heartburn			Fainting		
Extremity(s) Discolored			Jaundice			Head Injury		
Hair Loss on Legs			Liver Disease			Headaches		
Heart Murmur			Rectal Bleeding			Memory Loss		
Heart Tests (Not EKG)			Abdominal X-Ray tests			Numbness		
High Blood Pressure			Antacid Use			Paralysis		
History of Heart Attack			Black Tarry Stools			Speech Disorders		
Leg Pain – Walking			Change in Frequency of BM			Strokes		
Recent Electrocardiogram			Change in Stool Caliber			Tingling		
Rheumatic Fever			Change in Stool Consistency			Tremors		
Short of Breath –Exertion			Decreased appetite			**MUSCULOSKELETAL**		
Short of Breath – Lying Flat			Excessive Hunger			Arthritis		
Short of Breath – Sleeping			Excessive Thirst			Joint Pain		
Swelling of Legs			Gallbladder Disease			Gout		
Thrombophlebitis			Hemorrhoids			Back Problems		
Ulcers on legs			Hepatitis			Deformities		
ALLERGY			Infections			Joint Stiffness		
Coughing			Laxative Use			Muscle Cramps		
Coughing with Exercise			Nausea			Muscle Stiffness		
Hives			Rectal Pain			Paralysis		
Itchy Eyes			Swallowing Problem			Restricted Motion		
Itchy Nose			Vomiting			Weakness		
Recurrent Infections			Vomiting Blood			**PSYCHIATRIC**		
Runny Nose			**SKIN**			Depression		
Sneezing			Eczema			Behavioral Change		
Stuffy Nose			Itching			Disorientation		
Watery Eyes			Dryness			Disturbing Thoughts		
Wheezing			Bruise Easily			Excessive Stress		
Wheezing with Exercise			Hair Dye			Hallucinations		
ENDOCRINE			Hair Texture Change			Memory Loss		
Weakness			Hives			Mood Changes		
Weight Gain			Lumps			Nervousness		
Weight Loss			Mole Increase Size			Psychiatric Disorders		
Cold Intolerance			Nail Appearance Change			**HEMATOLOGIC/LYMPH**		
Excessive Urination			Nail Texture Change			Anemia		
Fatigue			Rashes			Bleeding Easily		
Goiter			Skin Color Change			Blood Clots		
Heat Intolerance						Bruise Easily		
Increased Thirst						Lumps		
Neck Pain						Radiation Exposure		
Sweats						Swollen Glands		
Thyroid Trouble						Transfusion Reaction		

I have completed this Health Questionnaire to the best of my ability. Should I have any change in my health status I will notify Andersen Orthopedics, APC.

Patient/Guardian Signature	Date	Physician Signature	Date

Andersen ORTHOPEDICS
A Professional Corporation

5924 Stoneridge Drive, Suite 103 Pleasanton, CA 94588
www.andersenorthopedics.com

PATIENT INFORMATION & DEMOGRAPHICS

(Please fill out completely)

PATIENT INFORMATION

Full Name: Last **First** **Middle** **(Suffix)**

Date of Birth (mm/dd/yyyy): **Sex:** ☐ Male ☐ Female **Social Security Number:**

Language Preference if not English: **Other communication issues? N___ Y___(what):_____**

Address (Street or PO Box) **City** **State** **Zip**

Home Phone: **Cell Phone:** **Work Phone:** **Email:**

Communication Preference:
(Please Indicate below how you prefer to be contacted) Can we leave confidential voicemails on this number?

☐ Home Phone: _____ ☐ Yes ☐ No

☐ Cell Phone: _____ ☐ Yes ☐ No

☐ Other: _____ ☐ Yes ☐ No

Employer: **Occupation:** **Employer Address:**

Preferred Pharmacy: **Location:** **Phone:**

Primary Care Doctor: **Address:** **Phone:** **Fax:**

HISTORY OF PROBLEM

Reason for today's visit:

First Symptom or Date of Injury:

How Did Injury Occur & When:

Injury a result of auto accident? ☐ Yes ☐ No **Is this a work-related injury?** ☐ Yes ☐ No
(If Yes, see Workers Compensation section)

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EMERGENCY CONTACT

Emergency Contact Name:		
Relationship to Patient:	**Responsible Party Address:**	
City:	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Cell Phone:**

INSURANCE INFORMATION

Primary Insurance Company:	**Member ID:**	
Name of Policy Holder:	**Date of Birth:**	**Group ID:**
Secondary Insurance Company:	**Member ID:**	
Name of Policy Holder:	**Date of Birth:**	**Group ID:**

WORKERS COMPENSATION

Worker's Compensation Carrier:	**Phone:** **Fax:**
Carrier Address:	**Phone:** **Fax:**
Adjuster Name:	**Phone:**
Nurse Case Manager Name:	**Phone:**
Claim #:	

I acknowledge that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability and that any questions that I may have had have been answered to my satisfaction. I will not hold Andersen Orthopedics, A Professional Corporation or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

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CONSENT & AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and Agreement for Treatment, please sign your name below to accept the terms of this agreement.

I hereby acknowledge that I or the entrusted minor need medical care and treatment, and I authorize Andersen Orthopedics, A Professional Corporation to provide treatment as necessary, release information pertaining to my treatment for insurance purposes, and to receive direct insurance payments otherwise payable to myself for services rendered. I give consent to Andersen Orthopedics, A Professional Corporation to perform necessary or appropriate tasks for proper orthopedic examination, diagnosis, and treatment of the medical condition. This may include, but is not limited to: examination, injections, local anesthesia, in-office procedures, bracing, casting, radiographs, diagnostic imaging, and wound care.

I hereby acknowledge that my questions regarding this agreement have been fully answered.

Patient Name: _____ DOB: _____

Patient/ Guardian Signature: _____ Date: _____

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FINANCIAL POLICY

I hereby assign and transfer to Andersen Orthopedics, A Professional Corporation, the benefits, monies and sums or other credits payable to myself or child for treatment of their medical conditions, or other insurance policy, or any other state, federal or private insurance policy which might be applied toward payment of or reimbursement for any and all services rendered or goods supplied as a result of treatment contemplated by this agreement. If for any reason I am unable to assign or transfer such rights, I hereby authorize and appoint Anderson Orthopedics, A Professional Corporation, as my agent with respect to the pursuance, receipt and application of such funds as it sees fit.

Financial Responsibilities: I understand that I am financially responsible to pay in full in the event that my health insurance does not reimburse in full for services rendered by Andersen Orthopedics, A Professional Corporation. I understand that I am responsible for paying co-payments, deductible, coinsurance and any charges for non-covered services as determined by my insurance. Should my account be referred to a collections agency, I agree to pay these collection expenses.

Medicare Authorization: I certify this information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Andersen Orthopedics, A Professional Corporation and its physicians and providers rendering service during my treatment(s).

I understand that I may be referred for further medical services to other facilities or physicians and providers that are not agents of Andersen Orthopedics, A Professional Corporation. For example this includes outpatient surgery centers, hospitals physical therapists, medical supply companies, and medical imaging facilities. Andersen Orthopedics, A Professional Corporation is not responsible for these facilities or practitioners and the financial relationship will be between the patient and the outside facility or provider and not Anderson Orthopedics, A Professional Corporation.

Non-Sufficient Funds Checks: There is a $25 charge for any check returned due to insufficient funds.

Late Cancellation/No Show Policy: Just like we respect your time we ask that you respect ours. We try our very best to remain on time as we know schedules are busy. We ask that you call as soon as you know you are unable to make the appointment so that we may make this spot available for other patients in need. *If continual late arrivals and no shows occur by an individual then a $25 fee will be charged to the individual and a charge of a full office visit in the amount $166.16 for each time after that.*

We understand that there are extenuating circumstances and we are more than willing to accommodate in that case. Please notify our office at your earliest convenience should such an event occur.

My questions regarding this financial policy/ consent and agreement have been fully answered.

_____ _____

Patient or Patient Representative Signature **Date**

_____ _____

Relationship to Patient **Witness**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Shortened Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to provide you with important information regarding how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice is a shortened version of the full legally required Notice of Privacy Practices (NPP) which is available upon request, so please refer to the Complete Notice for more detailed information.

Use and Disclosure of Your Protected Health Information (PHI)

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We will use this information about your health mainly to provide you with **treatment**, to arrange **payment** for our services, or for some other business activities which are called, **health care operations**. After you have read sign to acknowledge this NPP, we will ask you to sign a Consent Form to agree to be treated and to let us use and share your information as necessary. ***If you do not consent and sign the Consent Form***, ***we cannot treat you.***

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an **Authorization** to allow this.

We will keep your health information private, however there are times when the law requires us to use or share it, such as:

1. When there is a serious threat to your health and safety or to the health and safety of another individual or the public.
2. Law enforcement official requires us to do so.
3. Lawsuits and legal or court proceedings.
4. Worker's Compensation and similar benefit programs.

There are additional situations less common that are described in the complete version of the Notice of Privacy Practices, which is available upon request in our office.

Your Rights Regarding your Healthcare information

1. **Inspect and Copy:** You have the right to inspect and obtain a copy of your protected health information, such as your medical records, for so long as we maintain the information. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records, except as disallowed by your insurance.
2. **Restriction on Protected Health Information (PHI):** You have the right to ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You also have the right to ask us not to disclose any part of your PHI to certain individuals, such as family members or friends. If we do agree to your request, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. **Restriction of PHI Communication:** You have the right to request confidential communications from us by alternative means or at an alternative location. For example, you may ask us to call you at home and not work regarding your appointments or health information.
4. **Amend:** If you believe the information in your records in incorrect or incomplete, you have the right to request an amendment of PHI in a designated record set for so long as we maintain this information.
5. **Copy of Notice:** You have the right to a copy of this notice. If we change this NPP, we will provide an updated version in our office upon request.
6. **Accounting and Disclosures:** You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
7. **Complaints:** You have the right to file a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. Filing a complaint will not change the health care we provide you in any way.

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If you have any questions regarding this Notice, please contact our Privacy Officer at (925) 400-6900.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have read and received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this Notice should it be amended, modified, or changed in any way.

_____
Patient or Representative Name (Please Print)

_____ _____
Patient or Representative Signature Date

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION:

Medical information can be discussed with:

☐ Patient only
☐ Family member or friend:
Please list name/relationship

_____
_____
_____
_____

☐ Physician _____
☐ Other _____
☐ No Restrictions
☐ Other Restrictions

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Notice of Physician Ownership
Notice to Patients

Please read carefully to the information contained in this notice.

1. Andersen Orthopedics, APC distributes DME
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use alternative healthcare facilities.
3. You will not be treated differently by your decision to obtain healthcare services at an alternative facility.

If you have any questions in regards to this notice please feel free to ask you physician or and representative of Andersen Orthopedics, APC.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the notice and understand that your physician has an ownership interest in the above entities.

_____ _____

Signature of Patient

Signature of Parent or Guardian
(if applicable)

_____

Print Name of Patient

Date: _____