



# NEWPORT

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## ORTHOPEDIC INSTITUTE

### New Patient Packet

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Thank you for choosing Newport Orthopedic Institute. Our office looks forward to serving you.

#### **Prior to your appointment**

- Please complete the attached New Patient paperwork. Be sure to read the Financial Policy and Notice of Privacy Practices prior to completing the acknowledgement.
- You will receive an automated phone call the day before your appointment reminding you of your appointment time.
- If for any reason you are unable to keep your confirmed appointment, please call our office to reschedule your visit to suit your needs.
- Note our telephone hours are 8:00am – 5:00pm M-F, someone will be happy to assist you by calling (949) 722-5025.
- Visit our web-site at [www.NewportOrtho.com](http://www.NewportOrtho.com) to become more familiar with our office and your Physician.

#### **The day of your appointment**

- There are additional steps to the registration process that must be completed at the office on your first visit, so please be sure to arrive 30-minutes early with your completed paperwork so that you can make your appointment time.
- Bring your insurance card(s) or a legible copy. If for any reason you do not have a copy of your insurance card, please contact your insurance carrier prior to your arrival and have proof of eligibility faxed to (949) 630-4953.
- Means for satisfying the co-payment required by your insurance company or un-met deductible.

Thanks again for choosing Newport Orthopedic Institute!



# Newport Orthopedic Institute

Your Doctor has requested that this form be completed.

Please Print

Please Print

Doctor: \_\_\_\_\_

Huntington Beach  Newport Beach

## PATIENT INFORMATION

Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

Sex:  M  F

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Married  Single  Divorced

Phone: \_\_\_\_\_  Home  Work  Other

Primary Physician: \_\_\_\_\_

Phone: \_\_\_\_\_  Home  Work  Other

Referral Source: \_\_\_\_\_

Employer: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Was this an injury?  Yes  No Date of Injury \_\_\_\_\_

Where did injury occur? Work \_\_\_\_\_ Auto \_\_\_\_\_ Home \_\_\_\_\_ School \_\_\_\_\_ Other: (Specify) \_\_\_\_\_

## GUARANTOR

Same as Patient

Employer: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PRIMARY INSURANCE

Same as Patient  Same as Guarantor  Other

Insured Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Insured ID / Cert. #: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## SECONDARY INSURANCE

Same as Patient  Same as Guarantor  Other

Insured Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Company: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Insured ID / Cert. #: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## EMERGENCY CONTACTS

Name: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Newport Orthopedic Institute, A Medical Group, Inc. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Newport Orthopedic Institute, A Medical Group, Inc. in the collection of amounts due including, but not limited to, reasonable attorney's fees.

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Newport Orthopedic Institute, A Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release if all information necessary to secure payment.

I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party payer or because of pending legal claims.

Date: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

# Patient Health History

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex:  F  M Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Do you need an interpreter? \_\_\_\_\_

**Referred here by** (check one)  Self  Family  Friend  Doctor  Other Health Professional

Name of person making referral: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Internist: \_\_\_\_\_ Cardiologist: \_\_\_\_\_

Have you had a recent medical evaluation by one of these doctors? \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

## Past Medical History

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? \_\_\_\_\_

Do you now or have you ever had any of the following? (if yes, check box)

- |                                              |                                         |                                       |                                              |
|----------------------------------------------|-----------------------------------------|---------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Cancer Type: _____  | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Goiter              | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Rheumatic fever     |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> HIV/AIDS     | <input type="checkbox"/> Colitis             |
| <input type="checkbox"/> Nervous Breakdown   | <input type="checkbox"/> Leukemia       | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Psoriasis           |
| <input type="checkbox"/> Bad Headaches       | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Stroke       | <input type="checkbox"/> Childhood Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout           | <input type="checkbox"/> Tuberculosis |                                              |

List any other conditions you have had that are not already noted

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**Current Medications** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements)

**Drug Allergies:** Yes \_\_\_\_\_ No \_\_\_\_\_ To What? \_\_\_\_\_

**Type of Reaction:** \_\_\_\_\_

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you used blood thinners, such as Coumadin, Heparin, Aspirin, Ibuprofen, Alleve, or Plavix, with in the past 2 weeks? \_\_\_\_\_

Have you ever taken steroids, such as Prednisone or Medrol, by mouth? \_\_\_\_\_ If yes, when and for how long? \_\_\_\_\_

Do you take medication for Osteoporosis such as Fosamax, Actonel, or Boniva? \_\_\_\_\_

Date of last EKG \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last Blood draw \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last Chest X-ray \_\_\_\_/\_\_\_\_/\_\_\_\_

**List All Surgeries**

**Year**

**Reason**

1.		
2.		
3.		
4.		
5.		

**Social and Family History**

Have you ever smoked?  Yes  No Quantity/Amount: \_\_\_\_\_ If quit, how long ago? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No number per week \_\_\_\_\_ Has anyone ever told you to cut down on your drinking?  Yes  No  
 Do you use recreational drugs, such as marijuana, cocaine, meth?  Yes  No If yes, please list \_\_\_\_\_

Do you know of any blood relative who has or had any of the following? (check and indicate relationship)

- Cancer \_\_\_\_\_  Heart Disease \_\_\_\_\_  Rheumatoid Arthritis \_\_\_\_\_  Tuberculosis \_\_\_\_\_  
 Type \_\_\_\_\_  
 Leukemia \_\_\_\_\_  High Blood pressure \_\_\_\_\_  Osteoarthritis \_\_\_\_\_  Diabetes \_\_\_\_\_  
 Stroke \_\_\_\_\_  Bleeding tendency \_\_\_\_\_  Asthma \_\_\_\_\_  Goiter \_\_\_\_\_  
 Colitis \_\_\_\_\_  Alcoholism \_\_\_\_\_  Psoriasis \_\_\_\_\_  Autoimmune Disease \_\_\_\_\_

**SYSTEMS REVIEW**

As you review the following list, please check any of those problems, which have significantly affected you.

CONSTITUTIONAL	GASTROINTESTINAL	INTEGUMENTARY (SKIN AND/OR BREAST)
<input type="checkbox"/> Recent weight gain amount _____ <input type="checkbox"/> Recent weight loss amount _____ <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Fever  <b>Eyes</b> <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Double or blurred Vision <input type="checkbox"/> Itching eyes <b>EARS-NOSE-MOUTH-THROAT</b> <input type="checkbox"/> Bleeding gums  <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Runny nose <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Loss of taste <input type="checkbox"/> Dryness of mouth <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Difficulty in swallowing <b>CARDIOVASCULAR</b> <input type="checkbox"/> Pain in chest <input type="checkbox"/> Heart murmurs <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Sudden changes in heart beat <input type="checkbox"/> High blood pressure <b>MUSCULOSKELETAL</b> <input type="checkbox"/> Morning stiffness Lasting how long? <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle tenderness <input type="checkbox"/> Joint swelling List joints affected in the last 6 mos.	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting of blood or coffee ground material <input type="checkbox"/> Stomach pain relieved by food or milk <input type="checkbox"/> Blood in stools <input type="checkbox"/> Jaundice <input type="checkbox"/> Persistent diarrhea <input type="checkbox"/> Black stools <input type="checkbox"/> Heartburn <input type="checkbox"/> Increasing constipation  <b>GENITOURINARY</b> <input type="checkbox"/> Difficult Urination  <input type="checkbox"/> Pain or burning on urination <input type="checkbox"/> Rash/ulcers <input type="checkbox"/> Blood in urine <input type="checkbox"/> Pus in urine <input type="checkbox"/> Cloudy, "smoky" urine <input type="checkbox"/> Discharge from penis/vagina <input type="checkbox"/> Getting up at night to pass urine <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Vaginal dryness  <b>RESPIRATORY</b> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty in breathing at night <input type="checkbox"/> Wheezing (asthma) <input type="checkbox"/> Swollen legs or feet <input type="checkbox"/> Cough  <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Easy bruising <input type="checkbox"/> Redness <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Hair loss <input type="checkbox"/> Tightness <input type="checkbox"/> Nodules/bumps <input type="checkbox"/> Color changes of hands or feet in the cold <b>NEUROLOGICAL SYSTEM</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Night sweats <input type="checkbox"/> Sensitivity or pain of hands and/or feet <input type="checkbox"/> Memory loss  <input type="checkbox"/> Fainting <input type="checkbox"/> Muscle spasm <input type="checkbox"/> Loss of consciousness <b>HEMATOLOGIC/LYMPHATIC</b> <input type="checkbox"/> Transfusion? When <input type="checkbox"/> Swollen glands <input type="checkbox"/> Tender glands <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency  <b>PSYCHIATRIC</b> <input type="checkbox"/> Excessive worries <input type="checkbox"/> Easily losing temper <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep <b>ENDOCRINE</b> <input type="checkbox"/> Excessive thirst <b>ALLERGIC/IMMUNOLOGIC</b> <input type="checkbox"/> Frequent sneezing <input type="checkbox"/> Increased susceptibility to infection

Patient's Name \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Physician Initials \_\_\_\_\_



## FINANCIAL POLICY

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We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and agree to prior to any treatment.

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.**

### Insurance Billing

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60-days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

**HMO Plans** (with which we are contracted): All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment.

**PPO Plans** (with which we are contracted): We have negotiated rates with your insurance company. Your co-insurance and unmet deductible is your responsibility and payment is due at time of treatment.

In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts.

**Medicare:** We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance regardless of payment from a secondary insurance.

### Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### Cash patients

All services must be paid in full at time of treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit with the Physician.



### **Returned checks**

A \$25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.

### **Administrative Fee**

All co-pays will be collected at the time of service. If a patient does not submit payment at the time of service, the patient will be billed for the co-pay and a \$15 Administrative Fee will be added to cover the cost of billing and collections.

### **Surgery Deposits**

Newport Orthopedic Institute charges only for professional services provided by your physician. There will be additional billing directly to you from the facility where your procedure is performed, the anesthesiologists and other assistants that your surgeon may require. Once a decision for surgery is made, an Insurance Coordinator will contact your insurance carrier to confirm eligibility of benefits. At this time the Surgery Scheduler will provide you with an estimated cost of the Physician's professional services along with your estimated responsibility. This process normally happens within two business days of scheduling your procedure. The estimated responsibility will be collected as a deposit at the time of your pre-op appointment.

### **Durable Medical Equipment**

Newport Orthopedic Institute provides Durable Medical Equipment (DME) as ordered by your physician. Your insurance will be billed in accordance to your insurance coverage guidelines; however, you will be responsible to pay for unpaid balances and co-insurance rates. Some DME products are not covered by insurance, in which case, you will be notified of the item and its cost. For better understanding of your DME coverage, contact your Insurance Provider. DME is intended for single patient use only. As that is the case, DME is not subject to returns.

### **Medical Records**

All Medical Record requests are subject to a clinical preparation fee of \$15.00. For diagnostic films, such as an X-ray, MRI, and CT scan, you will be charged the actual cost of films printed. The actual cost of shipping and handling will be added if applicable.



## Notice of Privacy Practices

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We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

The Notice of Privacy Practices explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. The policy in its entirety can be requested from the receptionist or found on our web-site. Please review it carefully. For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
  - Treatment
  - Payment
  - Health Care Operations
  - Notifications and Special Circumstance and the Law
  - Research and Marketing
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Your agreement only acknowledges that we have made available for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.



# NEWPORT

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## ORTHOPEDIC INSTITUTE

### Patient Policies

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#### **DME Acknowledgment of Driving Impairment**

(Not applicable for patients under 16 years of age)

While you are under the care of your Physician, you may be fitted into Durable Medical Equipment, or DME (Cam Walking Boots, Shoulder Slings etc). While the DME is to be utilized to protect or support your condition, by wearing the DME, it might impair your ability to operate automotive vehicles.

You might not be able to operate a vehicle safely due to the use of your DME, please arrange for proper transportation and use the proper precautions. If you have any questions regarding this matter, please ask the DME Coordinator at Newport Orthopedic Institute or your Physician.

#### **Medication Acknowledgement of Driving Impairment**

(Not applicable for patients under 16 years of age)

While you are under the care of your Physician, you may be prescribed medication that could impair your ability to operate a motor vehicle, heavy machinery or equipment.

Please refrain from operating a motor vehicle under the influence of prescribed medications that impair judgment. Arrange for proper transportation and use the proper precautions when taking prescribed medications. If you have any questions, please ask your Physician or your pharmacist.

#### **Diagnostic Testing Results**

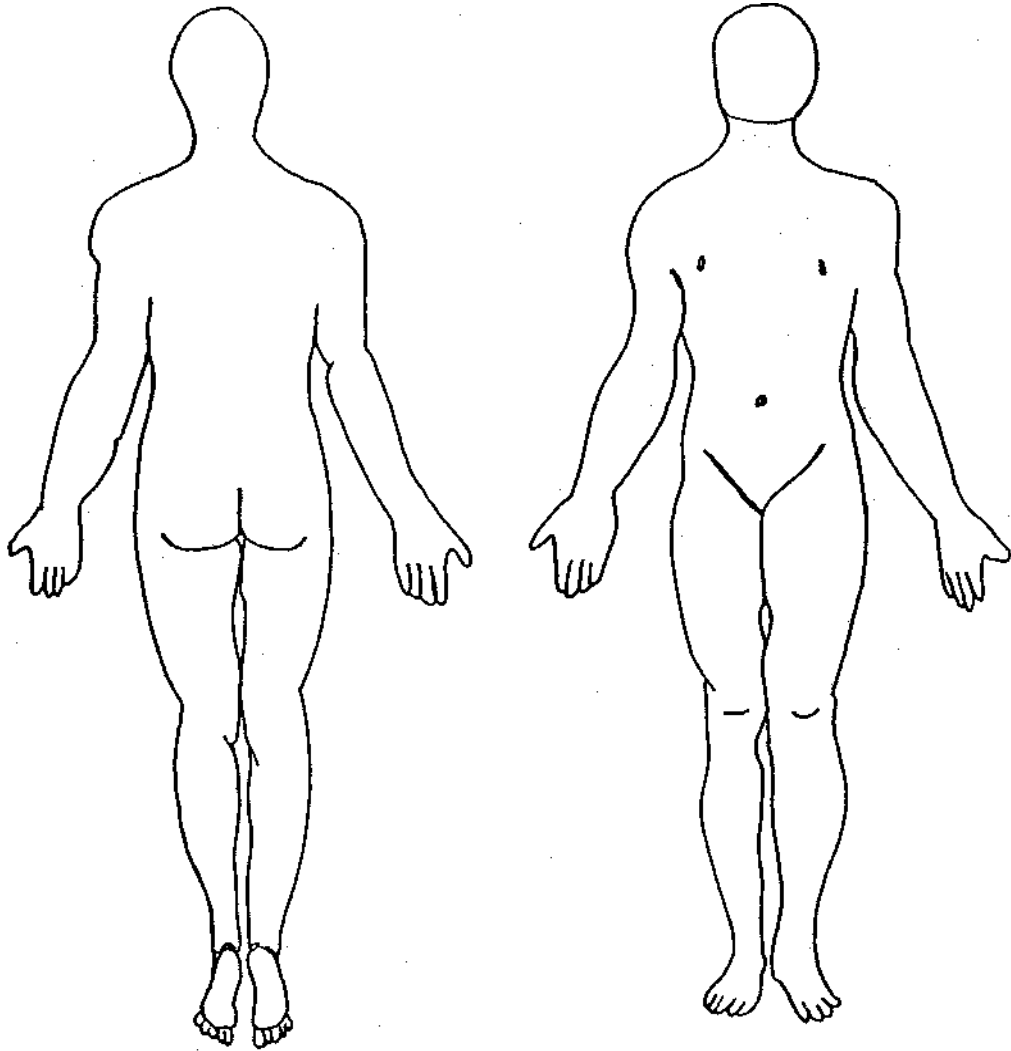
While under the care of a Physician/Provider with NOI, you may be sent to have diagnostic testing performed (MRI, CT-scan, bone scan, lab work). It is the patient's responsibility to return to the office to receive the results of any diagnostic testing. Most testing is completed at an outside facility. It is the patient's responsibility to obtain the results of all tests in addition to ensuring all outside results are sent to the Physician's office prior to the follow up appointment. Reports may be faxed to (949) 630-4903. NOI is able to directly access testing performed at Hoag Facilities as well as Newport Imaging Center.



NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE FILL OUT THIS PAIN DIAGRAM TO THE BEST OF YOUR ABILITY. MARK THE AREAS ON YOUR BODY WHERE YOU HAVE PAIN, AREAS OF NUMBNESS OR TINGLING, OR ANY OTHER BOTHERSOME SENSATION. PLEASE INCLUDE ALL AFFECTED AREAS AS WELL AS THE RADIATION OF SYMPTOMS. USE THE APPROPRIATE SYMBOLS BELOW. **PLEASE FILL OUT THE PAIN SCALE.**

NUMBNESS:00000    PINS & NEEDLES:XXXXX    PAIN OR ACHE:////



RATE YOUR PAIN

0=NO PAIN

10=EXTREMELY INTENSE

RIGHT NOW:	1	2	3	4	5	6	7	8	9	10
AT ITS WORST:	1	2	3	4	5	6	7	8	9	10
AT ITS BEST:	1	2	3	4	5	6	7	8	9	10

## Neck & Back History

Name: \_\_\_\_\_

Age: \_\_\_\_ Date of Injury: \_\_/\_\_/\_\_ Place of Injury: \_\_\_\_\_

Please describe what area of your neck and back hurts you: \_\_\_\_\_

\_\_\_\_\_

Describe exactly how your injury began: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How frequent is your pain: *Occasional Intermittent Frequent Constant*

How severe are your symptoms? *Mild Slight Moderate Severe*

How would you rate your pain on a scale of 0 to 10 with ten being the worst imaginable pain?

At the time you first experienced the pain: \_\_\_\_\_

What would you rate your pain now: \_\_\_\_\_

What would you rate it at its least over the past two weeks: \_\_\_\_\_

What would you rate it at its worst over the same two weeks: \_\_\_\_\_

What type of pain do you have? *Sharp Dull Aching Stabbing Electrical*

Where does your pain radiate? *Buttock Thigh Calf Foot Elbow Forearm Hand*

Is your Back/Neck pain: *Worse than, Less than, or Equal to* any leg or arm pain?

What kind of arm or leg symptoms do you have?

*Numbness Tingling Weakness Fatigue*

Of the actions below, circle those that make your pain worse:

*Bending*    *Lifting*    *Sitting*    *Driving*    *Deskwork*    *Housework*    *Coughing*  
*Straining*    *Sneezing*    *Standing*    *Walking*    *Lying down*

Of the actions across, cross out those that make your symptoms better.

List medications that you have tried for this problem. \_\_\_\_\_

Which of the medications have helped? \_\_\_\_\_

Have you had Physical Therapy?    *Yes*    *No*    Where? \_\_\_\_\_

Did it help you?    *Yes*    *No*

Do you experience loss of bowel or bladder control or awareness?    *Yes*    *No*

Please circle if you experience:    *Fever*    *Chills*    and/or    *Night sweats*

Have you experienced a sudden change in weight either up or down?    *Yes*    *No*

Is this injury related to your work?    *Yes*    *No*

Is this injury related to an automobile accident?    *Yes*    *No*

Have you had back surgery?    *Yes*    *No*    If so, when \_\_\_\_\_

What was done? \_\_\_\_\_

List any prior medical treatment: \_\_\_\_\_

List any prior similar complaint: \_\_\_\_\_