BASS
MEDICAL GROUP

ASSOCIATED OTHOPEDIC SURGEONS

19842 LAKE CHABOT ROAD, CASTRO VALLEY, CA 94546

(510) 886-8844 • FAX: (510) 886-2936 • gp.aosh@gmail.com

Gregg T Pottorff, M.D.

Fax Cover

Date: 8·22·17

To: Jenna @ Bass

From:

- ☐ **Dr. Pottorff**
- ☒ **Jess (asst. to Dr. P)**

Ph: 510-886-8844, x2114

Fax: 510-886-8859

Re: New Patient Forms.

Comments:

Please see attached.
Per your request.

Thank you!

The information contains in this transmission is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any use, dissemination, distribution or copying of this communication is strictly prohibited by law. If you have received this communication in error please notify us immediately and destroy this document. Thank you.

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PATIENT INFORMATION & REGISTRATION

Today's Date: ____________

PATIENT INFORMATON

Last Name: ____________
First Name: ____________
Address: ____________
City: ____________ State______ Zip______
County: ____________ Country:______
Home Phone: ____________
Cell Phone: ____________
Email Address: ____________

Date of Birth: ____/____/____ Age______
Social Security Number: ______-______-______
Gender: ☐Female ☐Male
Race: ☐African Amer/Black ☐Caucasian/White
☐Amer Indian/Alaska Native ☐Multi-Racial
☐Native Hawaiian/Pac Islander ☐Other
Ethnicity: ☐Hispanic, Latino, or Spanish Origin
☐Not Hispanic, Latino, or Spanish Origin

Patient Employer: ____________
Address: ____________
City: ____________ State______ Zip______
Employer Phone: ____________

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Spouse Name: ____________
Spouse Employer: ____________
Spouse Work Phone: ____________

Emergency Contact: ____________
Relationship to Patient: ____________
Emergency Contact Phone: ____________

Currently residing in a Nursing Home: ☐Yes ☐No
If yes, Name of Nursing Home: ____________

IF PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE THIS SECTION

Father's Name: ____________
Address: ____________
Phone: ____________ home, work, or cell
Date of Birth: ____/____/____
Social Security Number: ______-______-______
Employer: ____________

Mother's Name: ____________
Address: ____________
Phone: ____________ home, work, or cell
Date of Birth: ____/____/____
Social Security Number: ______-______-______
Employer: ____________

INSURANCE INFORMATION

Primary Insurance: ____________
Cardholder: ____________
ID No. ____________ Group No. ______
Relationship to Patient: ____________
Date of Birth: ____/____/____
Social Security Number: ______-______-______
Employer: ____________

Secondary Insurance: ____________
Cardholder: ____________
ID No. ____________ Group No. ______
Relationship to Patient: ____________
Date of Birth: ____/____/____
Social Security Number: ______-______-______
Employer: ____________

** <u>IF THIS IS A WORK RELATED INJURY, PLEASE FILL OUT THE WORK COMP INFORMATION ON THE NEXT PAGE</u>**

REFERRING SECTION

Referred By:

- [ ] Self
- [ ] Family Member
- [ ] Doctor ______________________
- [ ] Attorney ______________________
- [ ] Other ______________________

Referring Physician or Attorney

Address: ______________________

City: ____________ State______ Zip______

Phone: ______________________

PRIMARY CARE PHYSICIAN

Name: ______________________

Address: ______________________

City: ____________ State______ Zip______

Phone: ______________________

Fax: ______________________

WORK COMP SECTION

Have you reported this injury to your Employer?: [ ] Yes [ ] No

Have you involved an attorney?: [ ] Yes [ ] No

Work Comp Insurance Company: ______________________ Claim#: ____________

Adjuster: ______________________ Phone: ____________

Contact Person for Employer: ______________________ Phone: ____________

How did your injury occur?: ______________________

Insurance Authorization and Assignment: I hereby assign, to Associated Orthopaedic Surgeons payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

Financial Agreement: I understand that I am financially responsible for all charges whether or not they are covered by my insurance as well as any co-payment and co-insurance. In the event of non-payment for any of these costs, I understand I will be legally responsible for all costs involved with the collection of this account including all court cost, attorney fees, and any expenses incurred, should this be required.

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

Medicare Certification: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Associated Orthopaedic Surgeons for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents of any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature ______________________ Date ____________

Parent/Guardian Signature ______________________ Date ____________

Patient Name: ______________________ Date of Birth: ____/____/____

CURRENT MEDICATIONS

I AM NOT CURRENTLY TAKING ANY MEDICATIONS ☐

List any medication you are currently taking including items such as aspirin, vitamins, laxatives, calcium supplements, over-the-counter medications, etc. If you need additional space, please write on the back of this page. Thank you.

Name of Medication	Dosage	Frequency	How long have you taken this medication	This medication has helped: A Lot	Some	None
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

* Pharmacy Name: ______________ Location: ______________ Phone: ______________

ALLERGIES (Please list your allergies)

NO KNOWN ALLERGIES ☐

Name of Food, Drug or Item	Reaction	Name of Food, Drug or Item	Reaction

TODAY'S VISIT

Describe the reason for your visit today: ______________

Have you seen a physician for today's problem? ☐Yes ☐No

Who? ______________

What was the diagnosis of the other physician? ______________

What tests/procedures did the other physician order?

☐DEXA scan ☐X-ray ☐Bone scan ☐MRI ☐Other

Date of test/procedure: ______________

Results of test/procedures: ______________

Is this problem...

The result of an accident? ☐Yes ☐No

Auto related? ☐Yes ☐No

Work related? ☐Yes ☐No

Have you involved an attorney? ☐Yes ☐No

Date of injury: ______________

Date symptoms began: ______________

Describe any previous treatments for today's problem: ______________

HISTORY OF PRESENT ILLNESS

What are you being seen for today? ______________

What are your symptoms? ______________

When did you your symptoms first appear? ______________ If accident, when did it occur? ______________

Where did symptoms occur or accident take place? ______________

How did the symptoms manifest or occur? ______________

SOCIAL HISTORY

Relationship	Employment	Pregnancy	Handed	Exercise	Tobacco Use	Alcohol Use
☐Single	☐Employed	☐Pregnant	☐Left	☐Never	☐Cigarettes	☐Beer
☐Married	☐Unemployed	☐Not Pregnant	☐Right	☐Rarely	☐Cigars	☐Wine
☐Separated	☐Retired			☐Monthly	☐Chew	☐Mixed Drinks
☐Divorced	☐Disabled			☐Weekly	☐Quit	☐No alcoholic drinks
☐Widowed	☐Student			☐Daily	☐Never	

I drink ______ alcoholic drinks per ☐Day ☐Week ☐Month

I smoke ______ packs per day ☐1/4 ☐1/2 ☐1 ☐2+

I have smoked for ______ years

I have a history of substance abuse ☐Yes ☐No If yes, type: ______________

Occupation: ______________ Hobbies/recreations: ______________

Patient Name:____________________

Date:____________________

HISTORY OF PROBLEM

Please explain briefly why you are seeing the doctor: ☐Left ☐Right____________________

____

First Symptom or Date of Injury:____________________

How did the injury occur and when?____________________

Was an automobile involved:

☐ YES ☐NO Date of accident:________________

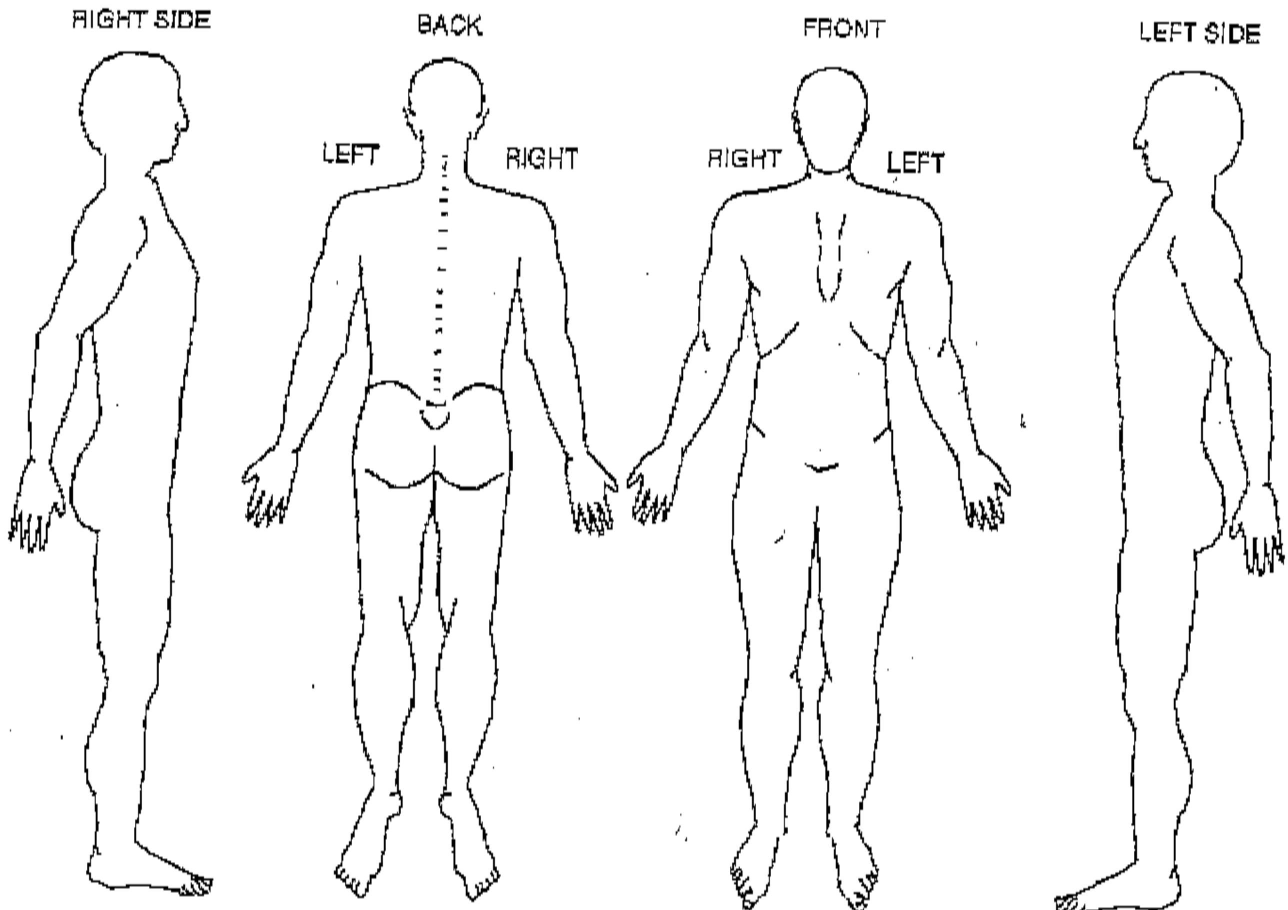
Name of Attorney:________________ Phone:________________

Was this injury at work?

☐ YES ☐ NO

____

PLEASE MARK WITH AN X WHERE YOU ARE EXPERIENCING PAIN



Pain level: Please Circle: 0 (none) 1 2 3 4 5 6 7 8 9 10 (worst)

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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountabilty Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: ______________________________
Printed Name – Patient or Representative

____
Signature Date

____
Relationship to Patient (if other than patient)

Witness: ______________________________
Printed Name – Practice Representative

____
Signature Date

Patient Name: ______________________ Date of Birth: ____/____/____

PATIENT'S PAST MEDICAL HISTORY *Please check all that apply* NO PAST MEDICAL HISTORY ☐

- ☐ Anemia
- ☐ Ankle Swelling
- ☐ Anxiety/Panic Attacks
- ☐ Anesthesia Complications
  - ☐ *Malignant Hyperthermia*
- ☐ Arrhythmia
- ☐ Arthritis/Osteoarthritis
- ☐ Asthma/Lung Disease
- ☐ Bleeding Tendency
- ☐ Blood Clots/DVT
- ☐ Blood Thinners ________
- ☐ Bone/Joint Infection
- ☐ Bruise Easily
- ☐ Bunions
- ☐ Cancer ____________
  - ☐ *Chemo* ☐ *Radiation*
- ☐ Cardiac Problems
- ☐ Carpal Tunnel, Neuropathy
- ☐ Chest Pain, Angina
- ☐ Circulatory Problems
- ☐ Cirrhosis, Jaundice
- ☐ Claustrophobia
- ☐ Deafness or hearing trouble
- ☐ Depression
- ☐ Diabetes ☐ 1 ☐ 2
- ☐ Diverticulitis
- ☐ Emphysema or COPD
- ☐ Fainting/loss of consciousness
- ☐ Fatigue/Weakness
- ☐ Gall Stones
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack/MI
- ☐ Heart Condition (congenital)
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ HIV
- ☐ Hypertension (High BP)
- ☐ Irritable Bowel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ ☐ *Dialysis* ☐ *No Dialysis*
- ☐ Liver Disease
- ☐ Lumbar Disk Disease
- ☐ Lyme Disease
- ☐ Morning Stiffness
- ☐ Multiple Sclerosis
- ☐ Muscle Spasms
- ☐ Muscle Tenderness
- ☐ Muscle Weakness
- ☐ Myasthenia Gravis
- ☐ Numb/Tingling hands/feet
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Parkinson's Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Poly/Fibromyalgia
- ☐ Renal Failure
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Skin Problems/Disorders
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Stroke/TIA
- ☐ TB (Tuberculosis)
- ☐ Thyroid High Low
- ☐ TMJ (Jaw locks or pops)
- ☐ Ulcers/Reflux/GERD
- ☐ Vascular/Circulatory
- ☐ Varicose Veins
- ☐ Vertigo
- ☐ Other ______________________________

PAST SURGICAL HISTORY *Please check all that apply* NO PRIOR SURGERIES ☐ PROBLEMS WITH ANESTHESIA? ☐Yes ☐No

Orthopedic Surgery

- ☐ ACL Reconstruction
- ☐ Arthroscopy (Circle Below)
- ☐ Ankle Left Right
- ☐ Elbow Left Right
- ☐ Hip Left Right
- ☐ Knee Left Right
- ☐ Shoulder Left Right
- ☐ Wrist Left Right
- ☐ Back Surgery
- ☐ Previous Fractures? ______________________
- ☐ Ankle Replacement Left Right
- ☐ Carpal Tunnel Rel Left Right
- ☐ Hip Replacement Left Right
- ☐ Knee Replacement Left Right
- ☐ Shoulder Replace. Left Right

General Surgery

Describe other surgical procedures ____________________

____

____

____

____