MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC.

400 N. MOUNTAIN AVE., SUITE 310, UPLAND, CALIFORNIA 91786 (909) 920-0876 FAX: (909) 946-4926

Patient's Last Name	First	Int.	Responsible Party
Birth Date | Age | Sex	CA Driver's License #		PATIENT STATUS ☐ Single ☐ Married ☐ Minor ☐ Other
Social Security No.	Spouse's Name (or Mother's)		☐ Employed ☐ Full-time Student ☐ Part-time Student

Street Address	City/State	Zip	Phone No.
Mailing Address (if different)	City/State		Zip
Patient's Employer	Address		Phone No.
Spouse's Employer	Address		Phone No.
Patient's Occupation	Patients E-mail Address:		
Name of Referring Physician	Phone No.	Family Physician	Phone No.
Is this a new illness? ☐ Yes ☐ No **Were you injured?** ☐ Yes ☐ No	**How Injured?** ☐ Work ☐ Auto ☐ Other		**Date of Injury / Onset**

Briefly describe your problem

Name of Relative or Friend and Phone No. **in-case of an Emergency**

Primary Insurance Company name & Address			**Secondary Insurance Company name & Address**		
I.D. No. /or S.S. No.	Group No.		I.D. No./S.S. No.	Group No.	
PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ other			PATIENT RELATIONSHIP TO INSURED ☐ Self ☐Spouse ☐ Child ☐ other		
INSURED'S NAME (Last Name, First Name, Middle Initial)			**INSURED'S NAME** (Last Name, First Name, Middle Initial)		
INSURED'S ADDRESS (No. Street)			INSURED'S ADDRESS (No. Street)		
CITY	STATE	ZIP	CITY	STATE	ZIP
DATE OF BIRTH	TELEPHONE (INCLUDE AREA CODE)		DATE OF BIRTH	TELEPHONE (INCLUDE AREA CODE)	
Insured's Employer & Phone No.			Insured's Employer & Phone No.		

I hereby consent to treatment by Medical Center for Bone and Joint Disorders/Physical Therapy. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X: ______________________________ ______________________

Signature of patient or parent if minor **Date**

Patient Encounter Form

Patient Name:________________________________ Date:___________

Age:______ DOB:_____________ Sex: M____ F____

Dominant Hand: R____ L____ Both____

Height:_______ Weight:________

Is this injury: Work Related____ Auto Accident ____ Sports____ Other____

Specific Injury: Y____ N____ Date:_______________

Cumulative Trauma: Y____ N____ Dates:___________ to ____________

Body Parts Injured:____
____

How did injury occur:____
____

Chief Complaints:
Pain____ Weakness____ Numbness____ Tingling____ Instability____ Other____

Have you had X-Rays, MRI or CT Scan for this injury? Y____ N____
(If Yes, Facility_____________________ Phone #_______________________)

Work Status: Full Duty____ Off Work____ Modified Work____ Retired____

Allergies: Y____ N____ (If yes, please indicate _______________________
____)

Medications:____
____

Referring Physician:_____________________ Phone #:_________________

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________, ______________________ Date: __________
Last First

Age:_____ Date of Birth:__________ Height: ________ Weight:__________ Hand Dominance: Right ☐ Left ☐

Primary Care Physician: ____________________ Referring Physician: ____________________

HISTORY OF PRESENT INJURY OR ILLNESS

Which body parts would you like to have evaluated? ______________________________

____

On what date did your symptoms begin? ______________________________

Did you have an injury? Yes ☐ No ☐ Date of injury: __________ Is the injury work-related? Yes ☐ No ☐ N/A ☐

How did the injury occur? Please be specific. ______________________________

____

What body parts were injured? ______________________________

COURSE OF TREATMENT

Have you ever seen another physician/healthcare provider in relation to this injury or illness? Yes ☐ No ☐

If yes, please provide physician's/provider's name:______________________________

Are you currently being treated for this injury or illness? Yes ☐ No ☐

If yes, please provide physician's/provider's name:______________________________

What treatments, if any, have you received for this injury or illness?

Medication ☐ Physical Therapy ☐ Pain Management ☐ Cortisone Shots ☐ Casting ☐ Bracing ☐

Have you ever had surgery for this injury or illness? Yes ☐ No ☐ If yes, please indicate:

Date/Year	Procedure	Date/Year	Procedure

What diagnostic studies, if any, have you had for this injury or illness?

X-rays ☐ MRI ☐ CT scan ☐ EMG/NCV ☐ Bone scan ☐ Discogram ☐

PATIENT COMPLAINTS

Body part(s):	What symptoms are you presently having in the body part(s)?

PAST MEDICAL HISTORY

ACCIDENTS/INJURIES

Prior to the this injury or illness, did you ever have injury to these body parts that was work-related? Yes ☐ No ☐

Prior injuries, work-related:

Body part(s) injured (be specific, e.g., neck, upper Back, lower back, specific part of extremity)	Date	Employer

Prior to the this injury or illness, did you ever have injury to these body parts that was not work-related? Yes ☐ No ☐

Prior injuries, not work-related:

Body part(s) injured (be specific, e.g., neck, upper Back, lower back, specific part of extremity)	Date

MEDICAL ILLNESSES

Do you have any of the following conditions?

High Blood Pressure	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐	Cancer	Yes ☐ No ☐
Thyroid Disease	Yes ☐ No ☐	Stroke	Yes ☐ No ☐	What Type? ______	
Diabetes Mellitus	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐	Lupus	Yes ☐ No ☐	What Type? ______	
Seizure Disorder	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Asthma	Yes ☐ No ☐

Have you ever been diagnosed with HIV/AIDS? Yes ☐ No ☐

Have you ever been diagnosed with chronic hepatitis? Yes ☐ No ☐ Which hepatitis, A, B, or C? ______

PREVIOUS SURGERIES/HOSPITALIZATIONS

What surgeries (other than those previously listed) have you had in the past? ______

______

What hospitalizations have you had in the past? ______

CURRENT MEDICATIONS

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

ALLERGIES

Do you have any allergies to medication or other substances? Yes ☐ No ☐

If yes, please list and describe reaction: ____________

FAMILY HISTORY

Which medical illnesses does your mother have? (please check which apply)

High Blood Pressure	______	Heart Disease	______	Cancer	______
Thyroid Disease	______	Stroke	______	What Type?	____________
Diabetes Mellitus	______	Ulcer	______	Arthritis	______
Kidney Disease	______	Lupus	______	What Type?	____________
Seizure Disorder	______	Emphysema	______	Asthma	______

Which medical illnesses does your father have? (please check which apply)

High Blood Pressure	______	Heart Disease	______	Cancer	______
Thyroid Disease	______	Stroke	______	What Type?	____________
Diabetes Mellitus	______	Ulcer	______	Arthritis	______
Kidney Disease	______	Lupus	______	What Type?	____________
Seizure Disorder	______	Emphysema	______	Asthma	______

SOCIAL HISTORY

Employer: ____________ Occupation/Job Title: ____________

Job Duties: ____________

Do you use the following?

Alcohol Yes ☐ No ☐ How often? ______ drinks per (day/week/month). (please circle) How many years? ______

Cigarettes Yes ☐ No ☐ How many packs per day? ______ How many years? ______

Recreational Drugs Yes ☐ No ☐ How often? ____________ How many years? ______

Please list which recreational drug(s): ____________

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

Do you have children? Yes ☐ No ☐ How many? ______

REVIEW OF SYSTEMS

Do you CURRENTLY have? (if yes, please check appropriate boxes)

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Fatigue

SKIN
- ☐ Nail changes
- ☐ New lesions
- ☐ Rash
- ☐ Skin color changes

HEENT
- ☐ Double vision
- ☐ Eye pain
- ☐ Eye redness
- ☐ Decreased hearing
- ☐ Earache
- ☐ Ear ringing
- ☐ Nosebleeds
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Oral ulcers
- ☐ Sore throat

RESPIRATORY
- ☐ Chronic cough
- ☐ Decreased exercise tolerance
- ☐ Difficulty breathing
- ☐ Coughing up blood
- ☐ Sputum production
- ☐ Wheezing

BREAST
- ☐ Breast mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Skin changes

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg pains with walking
- ☐ Leg swelling
- ☐ Night awakening due to trouble breathing
- ☐ Palpitations
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Trouble swallowing
- ☐ Reflux

GENITOURINARY
- ☐ Vaginal discharge
- ☐ Menstrual irregularities
- ☐ Difficulty starting/stopping urinary stream
- ☐ Painful urination
- ☐ Change in urinary stream
- ☐ Increased frequency
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Nighttime urination
- ☐ Urinary retention
- ☐ Urethral discharge
- ☐ Impotence
- ☐ Penile lesions
- ☐ Testicular mass
- ☐ Testicular pain

MUSCULOSKELETAL
- ☐ Neck pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling

NEUROLOGICAL
- ☐ Loss of bowel control
- ☐ Dizziness/vertigo
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts

ENDOCRINE
- ☐ Appetite changes
- ☐ Cold intolerance
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Hair changes
- ☐ Sexual dysfunction

HEMATOLOGY
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding

If you have completed all sections in the above form and all responses are true to the best of your knowledge, please sign and date below.

Signature: ______________________________ **Date:** ____________________

Medical Center for Bone & Joint Disorders, Inc.
A California professional medical corporation
400 N. Mountain Avenue, Suite 310
Upland, California 91786

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices, that I have been advised that a copy of the current Notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

Signed: ______________________________ Date: ______________________________

Print Name: ______________________________ Telephone: ______________________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ____

____

____

Medical Center for Bone & Joint Disorders, Inc.
HIPAA Notice of Privacy Practices
Acknowledgment and Tracking Information

Name of Patient: ____

I authorize Scott Goldman M.D. and staff to provide and/or discuss my care and medical needs with the following individuals.

Name Relation Phone

1.____

2.____

I grant permission for Scott Goldman M.D. and staff to leave detailed messages at the following phone number.

______ - ______ - __________

Type:

__Home
__Work
__Cell

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: ☐☐Yes ☐☐ No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

____

____

Reasons for refusal:

____

____

Medical Center for Bone and Joint Disorders/Premier Physical Therapy

Financial Policies

Welcome to our Medical Office. We are committed to providing excellent health services to you, our patient. As part of our professional relationship, it is important that you have an understanding of our financial policy. Below we describe the financial policies of the clinic and we outline some suggestions to help expedite handling of potential insurance issues.

Because we see patients with many different types of insurance coverage and insurance plans, it is impossible for us to be familiar with the covered benefits, co-pays and deductibles for every patient. Although we are here to assist you, it is your responsibility to ensure that all services rendered to you by Medical Center for Bone & Joint Disorders/Premier Physical Therapy are paid in full.

Payment at the time of service is required. We accept cash, check and credit cards as forms of payment.

Patients with private medical insurance coverage. We have contracts with several insurance companies, and if your plan is one of these, we will bill the company directly. In this situation, there may be a contractual discount on the charge to the company for your services. If we do not contract with your company then the full charge will apply. You may be asked to satisfy the account yourself and to later contact your insurance company to obtain reimbursement. **Your payment is required at the time of service.**

Co-payments and deductibles. Co-payments and deductibles are amounts that your insurance plan requires us to collect from you **at the time of service.** If you know that your deductible has not been met, or that your insurance company will not cover services, we request that you notify us at the time of your visit. If we later receive payment from your insurance company, and discover that you have overpaid your portion of these charges, then we will gladly refund any overpayment.

Medicare patients. We participate with Medicare, which mean we accept a greatly discounted amount for the services we provide. Medicare will be billed for all covered services. Medicare designates some services as non-covered, which means they will not pay for them. If you wish to receive such services you will be responsible for the full charge.

Medi-cal patients. We do not participate with Medi-Cal, if you are a Medicare patient with Medi-Cal secondary we will gladly bill Medi-Cal but you must be eligible at the time of service or you will be responsible for any Medicare co-insurance/deductible. You will also be responsible for any share of cost. We will not accept cash from a Medi-Cal patient. You will not be reimbursed if we are eligible and do not disclose this information.

Surgical patients. We gladly verify and receive pre-authorization for the Surgeon fee prior to your service. All other vendors that are used hospital, anesthesiologist, pre-operative labs, durable medical equipment, etc....it is your responsibility to contact for coverage and rates.

Physical therapy limits. We will verify your physical therapy benefit. If you have had any therapy, including chiropractic care please inform the receptionist as this could affect your number of visits. You will be responsible for any visits that are not covered.

Patients without insurance coverage. Full payment is required at the time of service.

Civil Suits, Auto, Home, or Business Owners Claims. If you are involved in an accident or other suit and are seeking payment from the responsible party, **We expect payment at the time of service.** We do not bill the responsible party's insurance or attorney for your services due to the time it takes to settle these claims. Please do not request that we bill your regular insurance in these cases, as these claims will be denied.

Returned check. A fee of $35.00 will be assessed to your account should we receive a returned check for insufficient funds or no account.

Form Completion. We will be happy to complete relevant portions of insurance, FMLA, and social service forms, etc...and disability claims. Please contact Medical Records for fees.

Change in insurance policy. It is your responsibility to notify our office of any insurance policy change. Please be aware if the claims are denied for any reason, you will be responsible for the full charge.

I have read and understand this financial policy.

Signature of Responsible Party Date