Jon I. White, MD – Orthopedic Spine Surgeon
New Patient History

Name:_____ Today's Date:_____

Date of Birth: _____ Age: _____ Height: _____ft _____in Weight _____lbs

Primary Care Physician: _____ Office Phone Number:_____

Cardiologist: _____ Office Phone Number:_____

Other Specialist(s): _____ Office Phone Number:_____

Reason For Visit?_____

Duration/Length of symptoms?_____

Have you tried any of the following?

☐Physical Therapy (Duration: _____) ☐OTC Medications (Duration: _____)

☐At Home Stretching/Exercises ☐Epidural Steroid Injections ☐ Heat or Ice Therapy

WORK HISTORY

Employer:_____

Occupation:_____

☐Full Time ☐Part Time ☐Student
☐Retired ☐Unemployed

SOCIAL HISTORY

Marital Status:
☐Single ☐Married ☐Divorced ☐Widowed

Smoking History:
☐Smoker ☐Non-Smoker ☐Former Smoker

Do you drink alcohol?
☐Yes (Amount:_____) ☐No

Do you drink coffee?
☐Yes (Amount:_____) ☐No

PAST MEDICAL HISTORY

Have you ever experienced or been told by a doctor that you have any of the following conditions?

☐Anemia
☐Aneurysm
☐Blood Clots
☐Cardiac Arrhythmia
☐Cardiac Disease
☐Carotid Artery Disease
☐Congestive Heart Failure
☐Diabetes
☐Diphtheria
☐Gastrointestinal Bleed
☐GERD/Reflux
☐Heart Murmur
☐High Blood Pressure
☐High Cholesterol
☐Hypothyroidism
☐Kidney Disease
☐Lung Disease
☐Measles
☐MRSA Positive
☐Nephritis
☐Osteopenia
☐Osteoporosis
☐Peptic Ulcer Disease
☐Peripheral Vascular Disease
☐Scarlet Fever
☐Stroke/TIA
☐Other Conditions:_____
_____
_____
_____

SURGICAL HISTORY

Please list all surgical procedures (including any blood transfusions) and the year they were performed.

_____

_____

_____

_____

SIGNIFICANT INJURIES/HOSPITALIZATIONS

Please list any significant injuries or hospitalizations and the corresponding date.

_____

_____

_____

_____

MEDICATIONS

Please list **ALL** current prescription medication names **(Do not list vitamins or OTC meds)**

1.	8.	15.
2.	9.	16.
3.	10.	17.
4.	11.	18.
5.	12.	19.
6.	13.	20.
7.	14.	21.

Pharmacy Name _____ **City** _____ **Phone #**_____

ALLERGIES: ☐ No Known Allergies to Medications

_____

_____

FAMILY MEDICAL HISTORY

(example: cancer, diabetes, hypertension)

Father:_____

_____

Mother:_____

_____

REVIEW OF SYSTEMS

Have you experienced the following? circle

Weight Loss	Weight Gain	Fever/Chills
Headaches	Short of Breath	Chest Pain
Weakness	Swelling	Cough
Numbness	Bruising	Nausea
Irregular Heart Rate		Painful Urination
Visual Changes		Bleeding Tendencies

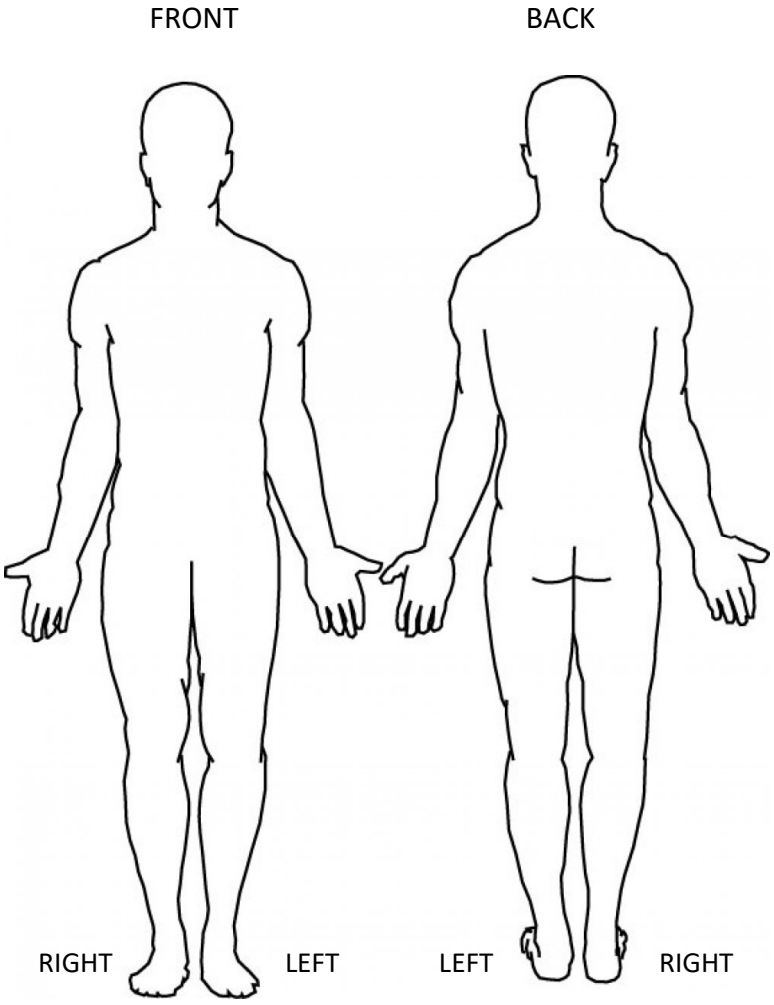
PAIN DRAWING

Name_____ Date_____

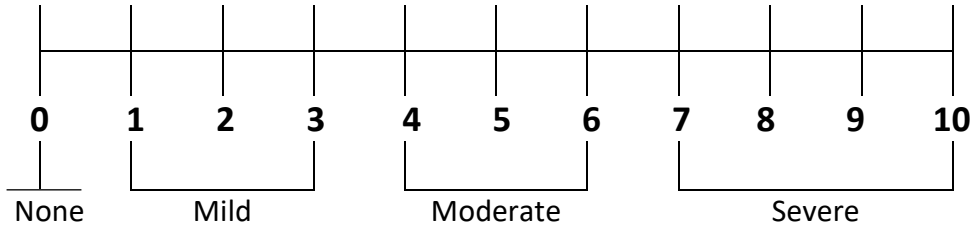
WHERE IS YOUR PAIN NOW? Mark the areas on your body where you feel the described sensations. Use the appropriate symbol (Chart Below). Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

Use the symbols below
To describe type of pain:

ACHE	^ ^ ^ ^ ^ ^ ^ ^ ^
NUMBNESS	0 0 0 0 0 0 0 0 0
PINS & NEEDLES	= = = = = = = = =
BURNING	X X X X X X X X X
STABBING	/ / / / / / / / /



PLEASE MARK ON THE LINE: How bad is your pain now? Please indicate with an "X" pertaining to the worst area.



PLEASE READ

Jon I. White, M.D.

Mediation Rx Protocols and Patient Responsibility Form

Narcotic medications will not be dispensed to any patients without approval from Dr. Jon I. White.

Requests for medication refills will only be honored by PATIENT requests with 72 business hours advance notice. NO refills will be granted by pharmacy requests! Medication requests will be presented to Dr. Jon I. White on Tuesdays and Fridays for authorization.

Medication refills **will not** be available after office hours, weekends or holidays.

Medication refills **will not** be granted by walk-in patients without prior written authorization by Dr. Jon I. White.

All medication dispensed to the patient is the responsibility of the patient, and is to be taken as directed by Dr. Jon I. White. No refills will be granted for patients who missed their last scheduled appointment. No refills will be granted if it has been longer than **6 months** since you have seen Dr. Jon I. White for a follow up visit.

I, _____ understand and agree with the instructions
(Print name)
given to me by Dr. Jon I. White.

Patient Signature _____ Date _____

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames)			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	
E-mail Address:			Driver's License #:
Was this an injury? ☐ Yes ☐ No	If yes, where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School		Date of injury:
Employer Name:		Occupation/Title/Position:	
Employer Address and Phone #:			
Emergency Contact Name:		Relationship:	Phone #:

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)			
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	
Employer Name:		Occupation/Title/Position:	
Employer Address and Phone #:			

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)
IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INS	Insurance Company:		Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:		Group #:	
	Claims Address & Phone #:			
	Insured's Name:	Relationship:		Insured's Date of Birth:
	Insured's Employer:		Insured's Social Security #:	
SECONDARY INS	Insurance Company:		Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:		Group #:	
	Claims Address & Phone #:			
	Insured's Name:	Relationship:		Insured's Date of Birth:
	Insured's Employer:		Insured's Social Security #:	

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original. **Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a cash patient with payment in full due at the time of service.** This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN _____ **DATE** _____

ORTHOPAEDIC SPECIALTY INSTITUTE

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____Date of Birth: ___/___/_____ MR #: _____

If minor, Parent/Guardian Name: _____

Release of Information

I authorize the release of information including diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _____

[ ] Child(ren)/Name(s): _____

[ ] Other: _____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # _____ [ ] my cell phone # _____.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) _____ between (time) _____.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: _____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____

Witness: _____ Date: _____

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Acknowledgement of Receipt of Notice of Privacy Practices and Notices to Consumers

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices as well as Consumers Notices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices and/or Consumer updates at each appointment.

NOTICE TO CONSUMERS

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE
(916) 561-8780
WWW.PAC.CA.GOV

NOTICE TO CONSUMERS

MEDICAL DOCTORS ARE
LICENSED AND REGULATED BY
THE MEDICAL BOARD OF CALIFORNIA

(800) 633-2322
WWW.MBC.CA.GOV

Signature: _____ 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
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

280 S. Main Street · Suite 200 · Orange, CA 92868 · Tel. (714) 634-4567 · Fax (714) 634-4569
16300 Sand Canyon Ave · Suite 511 · Irvine, CA 92618 · Tel. (949) 255-9890 · Fax (949) 255-9776

ORTHOPAEDIC SPECIALTY INSTITUTE

280 S. MAIN STREET · SUITE 200 · ORANGE, CA 92868 · TEL. (714) 634-4567 · FAX (714) 634-4569
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CONSENT FOR TREATMENT – NOTICE OF POLICIES

I hereby consent and authorize Orthopaedic Specialty Institute Medical Group of Orange County (OSI) healthcare providers to perform medical care, diagnostic tests, surgical care and other therapeutic measures, as may be indicated for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), healthcare provider(s), medical staff, and the company, of all responsibility resulting from my action.

I also authorize OSI, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payers (including but not exclusive of, private insurance, Medi-Cal, Medicare, Tricare, Work-Comp, etc.)

I acknowledge that I have been given the ability to review OSI's policies including Financial Policy.

FINANCIAL POLICY

- We will submit claims to your insurance company for all medical services rendered at OSI. Any other services related to your medical care not rendered at OSI (i.e. laboratory, pathology, hospital fees, outpatient surgery center fees, anesthesiologist, co-surgeon, etc.), will be billed by the entity providing those services. It is **your** responsibility to verify that OSI is part of your insurance plan. We will attempt to verify your eligibility and benefits with your insurance carrier; however, this does not guarantee that they will pay for the services provided, and you will remain financially responsible if they do not provide payment.

- **OSI accepts the following insurance plans**:

  - **Medicare** – pays 80% after the deductible has been met. We will bill your coinsurance for the remaining 20% as a courtesy; however, you are responsible for the 20% coinsurance of the Medicare allowable amount.
  - **Contracted PPOs and HMOs** – you are responsible for the payment of co-pay and deductible at the time of the service, as well as for any charges for which you failed to secure prior authorization (if necessary).
  - **Non-Contracted PPOs** – you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
  - **Self-Pay** (uninsured) - you are expected to pay in full at the time of the service.
  - **Worker's Compensation** – you are not responsible for any charges unless the case has been dismissed or denied.

Initials_____

- **Personal Injury/Motor Vehicle Accidents -** you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
- **Surgery Deposits** – once the decision for surgery is made, our surgery coordinator will contact your insurance carrier to confirm eligibility benefits and obtain authorization. The surgery coordinator will provide you with an estimated cost of your surgery. This amount will be collected as a deposit at or before the time of your pre-operative appointment.
- **Medical Records** – all medical records requests are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).
- **Divorce Related** – the parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all, or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- **Bad Debt** - patients who do not pay bills within 90 (ninety) days of the statement date, will be referred to a collections agency, and ***may be discharged from the practice for non-payment.***
- **Failed Appointment Charge for MRI –** we reserve the right to charge $25 (twenty-five) for each failed appointment not canceled at least 24 hours before the scheduled appointment time. This charge is not covered by your insurance.
- **Usual and Customary Rates -** our practice is committed to the best treatment for our patients. Our charges are considered usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary charges.

- **Financial Responsibility** – based on our contractual agreements with the insurance companies and our internal policies, we are informing you of the following:
    - Your health insurance deductibles and any expenses deemed not covered by your insurance company will be your financial responsibility.
    - All monies owed by you, such as office visits co-payments and non-covered services or supplies, are due at the time of the service.
    - If you are not prepared to pay any amounts due at the time of the visit, you will be asked to re-schedule the appointment, unless the physician determines that your medical condition prohibits this.

- **Method of Payment** - our office accepts the following forms of payment: credit cards, cash, money order, and checks. A $25 (twenty-five dollar) service charge will be assessed to your account for any returned check by your bank. This charge is not covered by your insurance.

Thank you for understanding our policies. If you have any questions or concerns, please do not hesitate to contact our office at **(714) 634-4567.**

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose to revoke them in writing.

_____

(Signature of Patient or Authorized Representative) (Printed Name) (Date)

_____

(If signed Above by Representative, Relationship of Signer to Patient) (Name of Patient if Different from Above)

Initials_____