

PACIFIC ORTHOPAEDIC ASSOCIATES

Matthew Lin, M.D.

David Huang, M.D.

Jonathan Chang, M.D.

Anthony Yang, M.D.

Benjamin Tam, M.D.

Eugene del Rosario, PA-C

Blanca Mora, PA-C

Sihuror Peak, PA-C

Freddy Chan, PA-C

Your personal information

		Date	Provider	
Last Name	First Name	Middle Initial	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address	City	State	Zip Code	
Home Phone:	Social Security #:		Birthdate:	
Spouse Last Name:	Spouse First Name:	Spouse Middle Initial:		
Work Phone:	Alternate Phone:		Description:	
Referring Provider	Phone			
Referrer's Address	City	State	Zip Code	
Primary Care Physician	Phone			
PCP's Address	City	State	Zip Code	
Pharmacy:	Phone	Fax		
Emergency Last Name	First Name	Middle Initial	Relation:	
Address Line 1:			Emer. Contact Phone	
City	State	Zip Code	Emergency Alternate Phone Description	

Your insurance information

Primary Insurance Information

Insurance Name			
Your contract or ID Number			
Address			
City	State	Zip	

Secondary Insurance Information

Insurance Name			
Your contract or ID Number			
Address			
City	State	Zip	

Is this a work injury? Yes No

Workers Compensation Carrier: _____

Were you injured in a motor vehicle accident? Yes No

Insurance Name: _____

Primary Subscriber Information

Last	First	M.I.	
Address			
City	State	Zip	
DOB	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

Secondary Subscriber Information

Last	First	M.I.	
Address			
City	State	Zip	
DOB	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

Date of Injury _____

Phone: _____

Date of Injury _____

Phone: _____

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Your Medical History

Last Name _____ First Name _____ Middle Initial _____ DOB: _____

Have you been diagnosed with any of the following problems? Please check the appropriate answer.

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alzheimer's	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Lung	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Prostate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Diseases: _____

Other Fractures: _____

Right Handed

Left Handed

Past Medical Information

Please describe your past orthopaedic problems

Current Medications

Please list any medications you are currently taking, including dosage and frequency

Past Surgery

Please list any major surgical procedures you've had

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

4. _____ Date _____

5. _____ Date _____

Have you ever had any complications from anesthesia? Yes No

Allergies Are you allergic to any medications / drugs? Yes No

If yes, please specify. _____

Your Family History

Has anyone in your immediate family had any major illnesses? Please check the appropriate answer.

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Lung	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alzheimer's	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CA Prostate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Other Diseases: _____

Other Fractures: _____

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Your Social History

Last Name	First Name	Middle Initial	DOB:
Occupation:	Employer:		
Education:	<input type="checkbox"/> Retired <input type="checkbox"/> Disabled		
Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Single

Other Considerations:

Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily Usage	Do you drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily Usage
Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily Usage	Do you use street Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type/Daily Usage
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you going through Menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you gone through Menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Lifestyle:

Activity Level: <input type="checkbox"/> Above Average <input type="checkbox"/> Average <input type="checkbox"/> Sedentary			
Exercise Frequency: <input type="checkbox"/> 2-3/week <input type="checkbox"/> 3-4/week <input type="checkbox"/> 5/week	<input type="checkbox"/> Daily	<input type="checkbox"/> Never	<input type="checkbox"/> Occasional
Type of Exercise:	Hobbies/Activities:		

Commercial insurance I hereby consent to Pacific Orthopaedic Associates using and/or disclosing my protected health information ("PHI") for my care, and the Practice's health care operations, and for such other uses that are permitted or required under federal or state law without my consent or authorization. Specifically, I authorize release of information necessary to file a claim with my insurance company and assign payment of benefits to the physician indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier.

In the event of my failure to pay any sums due and my account is referred to an attorney for collection, I agree to be responsible for reasonable attorney's fees. A copy of my signature below is as valid as the original.
Medicare I further certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims for payment purposes.

Signature _____ Date _____

Please Sign (Insured person)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the above named physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described on attached claim.

Please Sign I realize that this may not represent the full payment for services rendered and I will be responsible for balance due. Patients are responsible for all deductible amounts and out-of-network charges which are not covered by insurance companies.

PAYMENT OF SERVICES:

Please Sign I hereby authorize above named physician to release any information acquired in the course of my examination or treatment.

AUTHORIZATION TO RELEASE INFORMATION:

Please Note: In order to avoid problems with your billing, please sign all 3X's.
If patient is a minor, parent or responsible guarantor must sign.