Personal Information			
Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone/Carrier:		
Email Address:		Primary Physician:	
Gender: ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY):	Age:	SSN:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Race:	Ethnicity:	Emergency Contact:
Occupation:	Employer:	Employer Address:	
Is Patient a child? ☐ Yes ☐ No	Father's Name:		
	Mother's Name:		

How did you find us?	
☐ By Referring Physician:	☐ Online – which site?
☐ By Another Patient:	☐ Other:
Has any family member been seen in this office? ☐ Yes ☐ No	Family member name:
Have you seen a doctor at this facility? ☐ Yes ☐ No	

History of present injury	
Reason for visit:	
Date of injury:	Hand dominance: ☐ Right ☐ Left
Did this injury occur at work? ☐ Yes ☐ No	Is there a post or current work compensation claim? ☐ Yes ☐ No
Was this body part previously injured? ☐ Yes ☐ No	If so, how?
When and what were the first symptoms?	
Whom have you previously seen for this condition?	
What studies have been performed for this condition? (MRI, CT, E-ray, EMG, etc.):	

Insurance Information (if patient is a minor, parent information is required)		
Primary Insurance:	Subscriber:	
Subscriber Date of Birth:	Subscriber SSN:	
Group #:	ID #:	Plan #
Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain):		
Secondary Insurance:	Subscriber:	
Subscriber Date of Birth:	Subscriber SSN:	
Subscriber Employer:	Employer Phone:	
Group #:	ID #:	Plan #
Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain):		

I hereby authorize my insurance benefits to be paid directly to *Fremont Orthopaedic & Rehabilitative Medicine*. I understand I am financially responsible for non-covered services and balances remaining after insurance pay. I authorize *Fremont Orthopaedic & Rehabilitative Medicine* to release any information required to process this claim.

_____ _____

Patient or Guarantor Signature Date

Current Health			
Height:	Weight:	Pregnant or could be pregnant ☐ Yes ☐ No	
Medical conditions that I have		☐ No medical conditions that I know of	
☐ High blood pressure	☐ Stomach ulcers/gastritis	☐ Thyroid problems	☐ Osteoarthritis
☐ High cholesterol	☐ Stomach reflux/GERD	☐ Kidney problems	☐ Rheumatoid arthritis
☐ Heart problems	☐ Irritable bowel syndrome	☐ Prostate problems/BPH	☐ Osteoporosis/brittle bones
☐ Heart attack	☐ Asthma	☐ Liver problems/hepatitis	☐ Stroke/CVA
☐ Diabetes	☐ Emphysema/COPD	☐ HIV/AIDS	☐ Neuropathy
☐ Blood clot formation/DVT	☐ Pulmonary embolus	☐ Cancer	☐ Depression
☐ Blood flow problems/PVD	☐ Pneumonia	☐ Sleep Apnea	☐ Alzheimer's
Other medical problems I have/more info:			

Operations I have undergone in the past		☐ I have had no major operations in the past
☐ Appendectomy	☐ Heart surgery	☐ Shoulder surgery
☐ Tonsillectomy	☐ Cardiac catheterization	☐ Knee surgery
☐ Vasectomy	☐ Cardiac stent placement	☐ Previous bone or joint surgery
☐ C-Section	☐ Colonoscopy/endoscopy	
Other surgeries I have undergone/more info:		

Medications I am currently taking		☐ I am currently taking no medications regularly	
Medication	Dosage (mg)	How Often	I take it for my:

Allergies I have to medications	☐ I have no known allergies to any medications
Medication	**Type of reaction (rash, nausea, stopped breathing, etc.)**
Allergies I have to anesthesia	☐ I have no known allergies to anesthesia
If yes, describe:	

Family Medical History		☐ No medical problems in my family that I know of	
Medical problem:	**In my (mother, father, etc.):**	**Medical problem:**	**In my:**
☐ High blood pressure		☐ Osteoarthritis	
☐ High cholesterol		☐ Rheumatoid arthritis	
☐ Heart problems		☐ Other joint problems	
☐ Diabetes		☐ Osteoporosis/brittle bones	
☐ Asthma		☐ Neuropathy	
☐ Blood clot formation/DVT		☐ Alzheimer's	
☐Bleeding problems		☐ Cancer	
☐ Anesthesia problems		☐ Other:	
☐ Stroke/CVA		☐ Other:	

I am active in			
☐ No specific sport or exercise	☐ Cycling	☐ Basketball	☐ Gymnastics
☐ Walking for fitness	☐ Mountain biking	☐ Golf	☐ Skiing
☐ Exercising at the gym	☐ Hiking	☐ Tennis	☐ Snowboarding
☐ Weight training	☐ Baseball/Softball	☐ Volleyball	☐ Dance/cheer
☐ Running	☐ Soccer	☐ Lacrosse	☐ Other:
☐ Swimming	☐ Football	☐ Hockey	

Alcohol Use	**Tobacco Use**	**Recreational Drug Use**
☐ None/Rarely	☐ I don't smoke	☐ None
☐ 1-2 drinks/week	☐ I quit in _____ after smoking _____packs/day for _____ years	☐ Occasionally
☐ 1-2 drinks/day	☐ ½ to 1 pack/day	☐ Regularly
☐ Three or more drinks/day	☐ 2 or more packs/day	☐ Drugs I commonly use:
☐ Difficulty with heavy alcohol use in the past		

Review of symptoms – These are symptoms I commonly experience (check only if yes)

☐ Seasonal allergies/hay fever
☐ Dermatitis
☐ Frequent itching
☐ Skin reactions
☐ Reactions to Latex/rubber gloves
☐ Runny nose
Describe:_____

☐ Fever
☐ Fatigue
☐ Unexplained weight loss
☐ Weakness all over
Describe:_____

☐ Chest pain
☐ Heart palpitations
☐ Rapid heart beats
☐ Irregular heart beats
☐ High blood pressure
Describe:_____

☐ Changes in skin color
☐ Skin rashes
☐ Skin masses
☐ Skin sores/ulcers
☐ Skin cancers
Describe:_____

☐ Frequent thirst
☐ Frequent Hunger
☐ Hyperactivity
☐ Hypoactivity
☐ Growth changes
☐ Hair changes
Describe:_____

☐ Decreased hearing
☐ Ringing in the ears
☐ Dizziness
☐ Hoarseness
☐ Sinusitis
Describe:_____

☐ Bleeding tendency
☐ Easy bruising
☐ Lymph node enlargement
☐ Anemia
Describe:_____

☐ Abdominal pain
☐ Nausea
☐ Stomach ulcers/reflux
☐ Heartburn/indigestion
☐ Appetite change
☐ Change in bowel habits
☐ Diarrhea
☐ Constipation
☐ Loss of appetite
Describe:_____

☐ Bone fractures
☐ Joint sprains
☐ Joint swelling
☐ Low back pain
☐ Joint stiffness
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Fibromyalgia
Describe:_____

☐ Headaches
☐ Speech difficulty
☐ Stroke/TIA
☐ Numbness, tingling
☐ Seizures/epilepsy
☐ Balance problems, falls
Describe:_____

☐ Double vision
☐ Blurry vision
☐ Eye trauma
☐ I wear glasses/contacts
Describe:_____

☐ Mood swings
☐ Sleep problems
☐ Depression
☐ Anxiety
☐ Substance abuse
☐ Heavy alcohol use/drinking
Describe:_____

☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Chronic lung problems
☐ Chronic cough
Describe:_____

☐ Difficulty passing urine
☐ Incontinence
☐ Frequent urination
☐ Urinary tract infections
☐ Painful menstruation/PMS
Describe:_____

NEW CONDITION FORM

NAME: _____ DATE: _____

BIRTH DATE:_____SEX: M or F HEIGHT: _____ WEIGHT:_____

LIST AREAS OF CONCERN: _____
(PLEASE LIST LEFT OR RIGHT SIDE OF THE AREA OF CONCERN)

DATE(S) OF INJURY/LENGTH OF SYMPTOMS: _____

☺ **PLEASE FILL OUT COMPLETELY:**

1) DESCRIBE THE ACCIDENT (IF ONE OCCURRED): **(IF NO ACCIDENT SKIP TO #2)**

_____

_____

_____

2) WHEN AND WHAT WERE THE FIRST SYMPTOMS?

_____

_____

_____

3) WHAT TREATMENT (IF ANY) HAVE YOU HAD:

_____

_____

_____

4) CURRENT SYMPTOMS:

_____

_____

5) HAVE YOU HAD SIMILAR PROBLEMS IN THE PAST?

_____

_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF FORM ORTHOPAEDIC'S **NOTICE OF PRIVACY PRACTICES** WITH THE EFFECTIVE DATE OF APRIL 14, 2003.

_____ _____

SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE *DATE*

_____

PRINT PATIENT NAME

_____
RELATIONSHIP TO PATIENT (if signing for someone else)

*Please complete and sign the **Disclosure Form** if you wish anyone else to have your access to your records, or if you wish to allow another person to call or pick up items on your behalf.

Record Release/Disclosure Form

Patient Name: _____ Date of Birth: _____ Previous Name (if applicable): _____

I. My Authorization.
You may use or disclose the following health care information (check all that apply):

All my health information maintained by John W. Jaureguito, MD: _____

My health information relating to the following treatment or condition: _____

My health information for the date(s): _____

Other: _____

You may disclose this health information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason (s) for this authorization (check all that apply):

My request: _____ Other (specify): _____

This authorization ends:

On (date): _____ When the following event occurs: _____

II. My Rights.
I understand that I am not required to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However, I must sign an authorization:

To take part in a research study. OR
To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by John W. Jaureguito, MD based upon this authorization. I may not be able to revoke this authorization If its purpose was to obtain insurance. Two ways to revoke this authorization are:

Fill out a revocation form (available at the Front Desk). OR
Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name Relationship (parent, legal guardian, etc.)

FREMONT ORTHOPAEDIC & REHABILITATIVE MEDICINE

39180 Farwell Drive
Fremont, CA 94538
www.formortho.com

Our **Commitment to Quality Medical Care**

Fremont Orthopaedic and Rehabilitative Medicine is committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate your concerns to us or our staff. **Please tell us if you have a complaint or a complement – we value your feedback.**

Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and ***greatly*** value your feedback. If you would prefer that your comment be anonymous, please find a comment box in our waiting room.

If we are not able to answer your concern or complaint to your satisfaction, please contact the Alameda-Contra Costa Medical Association. If you have a complaint and we cannot resolve it together, we can refer you to an impartial dispute resolution committee of our local medical association. As members of the medical association, we have made a commitment to have any complaints you bring against us reviewed by a committee of peers. **Contact ACCMA at 510-654-5383.**

If the above suggestions are not satisfactory, or for any reason, you may contact the Medical Board of California. We offer this NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800/633-2322 or www.mbc.ca.gov).

I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.

_____

Patient/Patient Representative Signature Date

_____

Patient/Patient Representative Name – Please Print