

Personal Information			
Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone/Carrier:		
Email Address:		Primary Physician:	
Emergency Contact	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):	Age:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Race:	Ethnicity:	SSN:
Occupation:	Employer:	Employer Address:	
Is Patient a child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name:		
	Mother's Name:		
How did you find us?			
<input type="checkbox"/> By Referring Physician:		<input type="checkbox"/> Online – which site?	
<input type="checkbox"/> By Another Patient:		<input type="checkbox"/> Other:	
Has any family member been seen in this office? <input type="checkbox"/> Yes <input type="checkbox"/> No		Family member name:	
Have you seen a doctor at this facility? <input type="checkbox"/> Yes <input type="checkbox"/> No			

History of present injury	
Reason for visit:	
Date of injury:	Hand dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left
Did this injury occur at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a post or current work compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was this body part previously injured? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain):			
Secondary Insurance:		Subscriber:	
Subscriber Date of Birth:		Subscriber SSN:	
Subscriber Employer:		Employer Phone:	
Group #:	ID #:	Plan #	
Relationship of Patient to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical conditions that I have		<input type="checkbox"/> No medical conditions that I know of	
<input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart problems <input type="checkbox"/> Heart attack <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood clot formation/DVT <input type="checkbox"/> Blood flow problems/PVD	<input type="checkbox"/> Stomach ulcers/gastritis <input type="checkbox"/> Stomach reflux/GERD <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Prostate problems/BPH <input type="checkbox"/> Liver problems/hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Cancer <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteoporosis/brittle bones <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Neuropathy <input type="checkbox"/> Depression <input type="checkbox"/> Alzheimer's
Other medical problems I have/more info:			

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

Medications I am currently taking		<input type="checkbox"/> I am currently taking no medications regularly	
Medication	Dosage (mg)	How Often	I take it for my:

Allergies I have to medications		<input type="checkbox"/> I have no known allergies to any medications
Medication	Type of reaction (rash, nausea, stopped breathing, etc.)	
Allergies I have to anesthesia		<input type="checkbox"/> I have no known allergies to anesthesia
If yes, describe:		

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

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

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

Review of symptoms – These are symptoms I commonly experience (check only if yes)		
<input type="checkbox"/> Seasonal allergies/hay fever <input type="checkbox"/> Dermatitis <input type="checkbox"/> Frequent itching <input type="checkbox"/> Skin reactions <input type="checkbox"/> Reactions to Latex/rubber gloves <input type="checkbox"/> Runny nose Describe: _____ <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Weakness all over Describe: _____ <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Rapid heart beats <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> High blood pressure Describe: _____ <input type="checkbox"/> Changes in skin color <input type="checkbox"/> Skin rashes <input type="checkbox"/> Skin masses <input type="checkbox"/> Skin sores/ulcers <input type="checkbox"/> Skin cancers Describe: _____ <input type="checkbox"/> Frequent thirst <input type="checkbox"/> Frequent Hunger <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Hypoactivity <input type="checkbox"/> Growth changes <input type="checkbox"/> Hair changes Describe: _____	<input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Dizziness <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sinusitis Describe: _____ <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Easy bruising <input type="checkbox"/> Lymph node enlargement <input type="checkbox"/> Anemia Describe: _____ <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach ulcers/reflux <input type="checkbox"/> Heartburn/indigestion <input type="checkbox"/> Appetite change <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Loss of appetite Describe: _____ <input type="checkbox"/> Bone fractures <input type="checkbox"/> Joint sprains <input type="checkbox"/> Joint swelling <input type="checkbox"/> Low back pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Fibromyalgia Describe: _____	<input type="checkbox"/> Headaches <input type="checkbox"/> Speech difficulty <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Numbness, tingling <input type="checkbox"/> Seizures/epilepsy <input type="checkbox"/> Balance problems, falls Describe: _____ <input type="checkbox"/> Double vision <input type="checkbox"/> Blurry vision <input type="checkbox"/> Eye trauma <input type="checkbox"/> I wear glasses/contacts Describe: _____ <input type="checkbox"/> Mood swings <input type="checkbox"/> Sleep problems <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Substance abuse <input type="checkbox"/> Heavy alcohol use/drinking Describe: _____ <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic lung problems <input type="checkbox"/> Chronic cough Describe: _____ <input type="checkbox"/> Difficulty passing urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Painful menstruation/PMS Describe: _____

NEW CONDITION FORM
JOHN W. JAUREGUITO, M.D.

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.)

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