ORTHOPEDIC SPECIALTY ASSOCIATES

Mark G. Kowall, M.D., M.B.A. Mark F. Mooney, M.D.

Thank you for choosing our office to provide your orthopedic care. We are dedicated to providing you and your family with the finest medical care possible.

Patient Registration

Name:______________________________ Date: __________

Mailing Address: ______________________ City:____________ Zip code: ________

Home Phone:__________________ Cell Phone: __________________

Social Security #:__________________ Drivers License #:__________________

Primary Care Physician: ______________________________________

Preferred Local Pharmacy (Name/Location): ______________________________

Date of Birth: __________ Gender: __________

Height: ____________ Weight: __________ R or L Hand Dominant

Emergency Contact: ________________ Phone: __________________

Would you like to have access to our online Patient Portal where you may request an appointment, view prescriptions, view your account, make a payment, and find patient education materials? No ____ Yes ____

If Yes, provide your email address (Portal link is often marked as spam): ______________________

Social History

Marital Status: __________________ Number of Children: ____________

Occupation:____________________ or Retired

Ethnicity: Caucasian, Hispanic/Latino, Asian, African-American, Other, Unknown

Exercise (daily/weekly/never):__________ Exercise Type: ______________________

Tobacco (yes/no/quit) Type:__________ How Often: ________ How Long: ________

Alcohol (yes/no/quit): Daily 1-2x/week 1-2x/month Type: __________________

Substance Abuse (yes/no/quit): Type________________

78 S. Main Street, Templeton, CA 93465 Phone (805) 434-0999 Fax (805) 434-5267

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Chief Complaint

Doctor requesting Orthopedic Consult (**Which doctor sent you here?**): ______________________

Why are you seeing the doctor today? ______________________

Date of injury? ______________________

How did injury occur? ______________________

Treatment for this injury? ______________________

Medications taken for this condition? ______________________

What makes the pain better? ______________________

What makes the pain worse? ______________________

Have you had any x-rays or an MRI (when/where)? ______________________

Medical History

Current Medications - Dosage & Directions : ______________________

____

____

____

____

Medication Allergies: ______________________

Medical Problems (diabetes, arthritis, stroke, high blood pressure, heart attack, none):

Other: ______________________

____

____

Previous Surgeries and Dates: ______________________

____

____

____

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Family History

	Alive	Deceased	Age	Health status or cause of death
Father:				
Mother:				

Patient Review of Systems:

Are you currently having or have you had problems with: (Please explain)

Eyes: No ____ Yes____ : ________________________________

Ear/Nose/Mouth/Throat: No ____ Yes____ : ________________________________

Neck/Back: No____ Yes ____ : ________________________________

Respiratory: No____ Yes ____ : ________________________________

Cardiovascular: No____ Yes____ : ________________________________

Gastrointestinal: No____ Yes____ : ________________________________

Genitourinary: No____ Yes____ : ________________________________

Liver/Hepatitis: No____ Yes____ : ________________________________

High Blood Pressure: No____ Yes ____ : ________________________________

TB/AIDS/HIV: No____ Yes____ : ________________________________

Endocrine/Thyroid: No____ Yes____ : ________________________________

Psychological: No____ Yes____ : ________________________________

Numbness: No____ Yes____ : ________________________________

Arthritis: No____ Yes____ : ________________________________

Cancer: No____ Yes____ : ________________________________

Skin: No____ Yes____ : ________________________________

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Insurance Information:

Primary Insurance: _____________________________ Subscriber & D.O.B:________________________

Secondary Insurance: ___________________________ Subscriber & D.O.B:________________________

Tertiary Insurance: _____________________________ Subscriber & D.O.B:________________________

- I assign all my medical/surgical benefits to Orthopedic Specialty Associates and I understand that I am financially responsible for all charges I incur.
- I hereby authorize Orthopedic Specialty Associates to release all necessary information to secure payment of benefits. Given the complex nature of medical insurance we ask our patients to help us assure proper billing and authorizations.
- I hereby authorize Orthopedic Specialty Associates to release information to any provider that I am referred to, as well as request past medical information from any provider that has treated me.

Signed: ____ Date: ______________________

Acknowledgement of Notice of Privacy Practices

The Notice of Privacy Practices describes how we use or disclose your medical or health information. It also explains your rights as a patient under privacy regulations, as well as our responsibilities regarding your information.

I hereby acknowledge that I have the opportunity to receive and review a copy of the medical practice's Notice of Privacy Practices. A copy is available at any time at my request.

Signed: ____ Date: ______________________

Print Name: _______________________________________ Phone: _____________________

Patient Name (if different than above): ____

If not signed by the patient, please indicate:

___ Parent of Guardian of Minor Patient

___ Guardian or Conservator of an Incompetent Patient

___ Beneficiary or Personal Representative of Deceased Patient

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