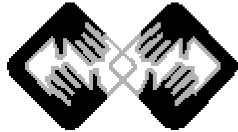


SAN DIEGO
HANDSPECIALISTS
CARE OF THE HAND & UPPER EXTREMITY
8008 FROST STREET · SUITE 403 · SAN DIEGO CA 92123
TEL 858-715-9200 FAX 858-715-9202

DORI NEILL CAGE, M.D., F.A.A.O.S.
LINDSEY S. URBAND, M.D., F.A.A.O.S.
GREGORY R. MACK, M.D., F.A.A.O.S.
JULIE R. GILBERT, M.D., F.A.C.S
HASSAN J. AZIMI, M.D.

Date of Appointment:______________ Time:___________

PLEASE PRINT:

Patient Name: ____ Gender:________

Date of Birth: ________ Age:_____ SSN:___________________ Marital Status:______

Address: ____

City: ________________________ State : ______ Zip Code:_________________

Home #:________________ Cell Phone #:_______________

Can a message be left on your answering machine? ____________

Who referred you to this office? ____

Height: __________ Weight:___________ Are you right or left handed?______________

E-mail address:____

Family Physician:____

Name of Physician or Medical group you would like us to send office visit notes to:

______________________________ Telephone number/fax:__________________

In case of emergency, whom may we contact? _______________ Relationship?_________

Phone #:__________________

Preferred Pharmacy: ____

Pharmacy Address: ____

Pharmacy Phone Number: ____

EMPLOYMENT

PATIENT:
Employer: ______________________________ Occupation: ____________________FT/PT
Address: ________________________________ Business Phone:________________
Are you currently working? Yes________ No__________
If the patient is a minor please fill out the parent's employment information above.

IF THIS IS A WORK RELATED INJURY/PROBLEM, PLEASE PROVIDE THE FOLLOWING WORK HISTORY <u>(Worker's Compensation only)</u>

When did you last work?

Are you working full duty?

If not, what are your current work restrictions? How long in your current status?

How long have you worked for your current employer?

How long have you been in this line of work?

Previous employment:

Do you have another job?

WHAT IS YOUR PRIMARY COMPLAINT? __________________________________
____

WAS THIS A SPECIFIC INJURY? IF SO, DATE OF INJURY: __/__/__
Please describe how it happened.____

____

<u>REVIEW OF SYSTEMS</u>

Please circle <u>any</u> symptoms you are **currently** experiencing (**not limited to hands and upper extremities**)

General: Fatigue; Fever

Skin: Easy Bruising; Nail changes; Skin Color Changes

HEENT: Headache; Visual Changes

Neck: Pain

Respiratory: Cough; Difficulty Breathing; Sleep Apnea; Wheezing; Shortness of Breath

Cardiovascular: Chest Pain; Fainting/Blacking out; Phlebitis; Rapid Heart Rate; Irregular Heart Rate

Gastrointestinal: Heartburn; Other

Neurological: Numbness; Tingling; Burning Pain; Weakness in Extremities

Psychiatric: Anxiety; Depression; Insomnia

Endocrine: Thyroid Problems; Prostate Problems

Hematology: Abnormal Bleeding; Blood Clots

ALLERGIES

	Yes	No	Reactions:
Penicillin	[ ]	[ ]	______________________________
Tape	[ ]	[ ]	______________________________
Iodine	[ ]	[ ]	______________________________
Shellfish	[ ]	[ ]	______________________________

Please list other allergies and reaction: ______________________________

____

FAMILY HISTORY

	Yes	No		Yes	No		Yes	No
Carpal Tunnel	[ ]	[ ]	Rheumatoid	[ ]	[ ]	Heart Disease	[ ]	[ ]
Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]	Hypertension	[ ]	[ ]
Glaucoma	[ ]	[ ]	Arthritis	[ ]	[ ]	Blood Disorders	[ ]	[ ]
Cancer	[ ]	[ ]						

SOCIAL

Please list your hobbies or leisure activities (tennis, golf, knitting):______________________

____

	Yes	No	Amount:
Do you smoke	[ ]	[ ]	__________________
Drink alcohol	[ ]	[ ]	__________________

CURRENT MEDICATIONS:

Name of medication	Dose	Frequency
______________________________	__________	__________
______________________________	__________	__________
______________________________	__________	__________
______________________________	__________	__________
______________________________	__________	__________
______________________________	__________	__________
______________________________	__________	__________

Please list all operations and hospitalizations:

Year	Operation(s)	Hospital & Location
_____	______________________________	______________________
_____	______________________________	______________________
_____	______________________________	______________________

ILLNESS & MEDICAL PROBLEMS:

Please mark relevant items and briefly explain:

- ☐ Glaucoma or other eye problems ______________________________________
- ☐ Pulmonary (asthma, wheezing, bronchitis, emphysema, pneumonia, tuberculosis, sleep apnea) ____
- ☐ Cardiac (hypertension, angina/chest pain, heart attack, heart murmur, irregular heartbeat) ____
- ☐ Bleeding tendency, easy bruising, nosebleeds, phlebitis, anemia) _______________

□ Stomach, duodenal ulcers, or hiatal hernia ___________________________________
□ Neurological problems (stroke, seizure disorder, paralysis) ______________________
□ Cancer (year, type, treatments) ____
□ Back pain or injury____
□ Mental illness (depression, anxiety, schizophrenia, bipolar) ____________________
□ Alcohol/Drug Addiction/Withdrawal_______________________________________
□ Difficulty with anesthesia (if yes, which type) _______________________________
□ Diabetes____
□ Thyroid Problem____
□ Other problems not listed above: ____
□ Exposure to Hepatitis, Tuberculosis, HIV/AIDS______________________________

FALL RISK SCREENING:

- Have you fallen in the past 3 months? Yes □, No □
- Do you require any walking aids? Yes □, No □
    - Bed rest or Nurse assistance for transferring? Yes □, No □
    - Crutches, cane, or walker? Yes, No □
    - Do you use the furniture in your home for balance? Yes □, No □
- Do you have an IV, PICC line or dialysis line? Yes □, No □
- How would you rate your ability to walk?
    - Normal □
    - Bedrest or immobile □
    - Impaired □
        - If impaired, do you forget to use your walker, cane, or assistive device?
            - Yes □, No □

DEPRESSION SCREENING:

□ Decline questionnaire.

1. In the past 2 weeks how often have you been bothered by - little interest or pleasure in doing things?
   □ Not at all
   □ Several days
   □ More than half the days
   □ Nearly everyday

2. In the past 2 weeks how often have you been bothered by – feeling down, depressed, or hopeless?
   □ Not at all
   □ Several days
   □ More than half the days
   □ Nearly everyday

*******We will give you assistance in processing your insurance claim, however, you must understand that you are responsible for payment for all professional services and/or collection agency fees.*******

RELEASE OF INFORMATION AUTHORIZATION**:** I authorize the release of any medical information necessary to process claims to my insurance company. I agree that a photographic copy of this authorization shall be as valid as the original. If the patient is a minor, the signature found below shall be that of the patient's parent, guardian, or conservator.

AUTHORIZATION TO PAY PHYSICIAN**:** I hereby authorize payment directly to Dr. Dori Cage, Dr. Lindsey S. Urband, Dr. Gregory R. Mack, Dr. Hassan J. Azimi, and Dr. Julie R. Gilbert of the Medical Expense Benefits otherwise payable to me, but not to exceed my indebtedness to said physician on account of the enclosed charge.

PERSONAL RELEASE OF MEDICAL INFORMATION
I authorize the following person(s) to discuss or be provided information related to my medical care including billing matters. (This does not include medical personnel and insurance companies)

____

LANGUAGE PREFERENCE ___________________ ***ETHNICITY*** (optional)______________

Name Relationship

___________________________ ________________________
___________________________ ________________________
___________________________ ________________________

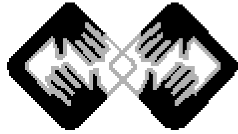
Print Patient's Name____

_____________________________________ Date:_________________
(Signature of Patient OR signature of Parent/Guardian if the Patient is a minor)

Witness Signature ______________________ Date: _________________

NOTICE TO CONSUMERS

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA (800) 633-2322
WWW.MBC.CA.GOV



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Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Always bring your health insurance card to your appointment. At the time of check in, please notify the front desk personnel of any changes in your personal information, such as insurance, address, and phone number.

2. Payment is required at the time of service including co-pay and any balance due on your account. In the event of surgery, if your insurance assigns you a deductible and/or co -insurance, a deposit may be collected prior to performing the surgery.

3. Please be sure prior to your visit that you have obtained referrals and/or authorizations required by your insurance company.

4. Please be sure to verify the participation status of your physician with your insurance plan and the billing department. If your physician is not part of your insurance plan, your portion of fees will most likely be higher. Ultimate responsibility for payment of all fees is yours. Please note, our doctors do not participate with Molina or Healthnet Medi-cal.

5. Keep in mind that an insurance policy is basically a contract between you and your insurance company. We will file all insurance claims for you. However, the ultimate responsibility for payment is yours.

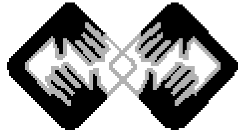
6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "non-covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I understand that I am responsible to pay for all services rendered, including, but not limited to, office visit, x-ray, casting and supplies, and any splints given to me by my physician. Please note, splints and other supplies may not be returned after they have been accepted by the patient, as they cannot be reused.

Patient Name:

Patient (or Legal Guardian) Signature: Date:

Staff Member: Date:



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Policies On Office Visits & Surgeries

Cancellation Policy on Office Visits & Surgeries

We recognize that your time is important and ours is too. When you book an appointment, you are holding a space on our calendar that is no longer available to our other patients. Out of respect for our doctors, staff and other patients, cancellations must be made 48 hours before your scheduled date of appointment. You must notify our office if you decide to cancel. Our phone number is 858-715-9200. Please call between 8 a.m. to 5 p.m. There is a cancellation fee of $75.00 if you cancel less than 48 hours before your appointment.

Late for Appointment Policy

You are considered late for your appointment when you arrive 15 minutes past your scheduled visit to our office or 15 minutes past your scheduled surgery. At this point, there is no guarantee that your doctor can see you or perform a surgery on you the same day and a $75.00 late fee will be charged to you.

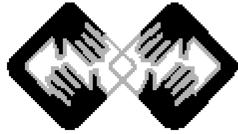
No Show Policy

A no-show is when a patient misses an appointment without calling our office. In this case, a $75.00 fee will be billed to you.

Patient's Printed Name: ____

Patient's Signature: ____

Date Signed: ____



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SAN DIEGO HAND SPECIALISTS MANAGEMENT, INC.
Consent for Use and Disclosure of Health Information

In signing this form you consent to the use and disclosure of your protected health information by San Diego Hand Specialists Management, Inc., our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review our Notice of Privacy Practices carefully. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change; however, a current copy may be requested when you are being seen as a patient.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on a treatment or service provided using this or prior consents may still be used or disclosed for the purposes of treatment, payment or healthcare operations.

By signing this form, I grant my consent to San Diego Hand Specialists Management, Inc., to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

____ ____________________

Signature of Patient or Surrogate Decision Maker Date

Relationship to patient (if applicable): ____

For Practice Use Only

Failure to obtain consent—check appropriate reason:

- ☐ Substantial communication barrier
- ☐ Emergency treatment
- ☐ Refusal to sign
- ☐ Other

Description:____

Practice Signature:___________________________________ Date: ______________________

Witness:____ Date: ______________________