SONORAN ORTHOPAEDICS

10240 W. Indian School Rd., Suite # 115
Phoenix, AZ, 85307
PHONE : (480) 582-9833
FAX : (480) 874-2041

Patient Information

Patient Name _____ Date of Birth _____ Gender: Female ☐ Male ☐

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS# _____ Employed By _____

How did you hear about us? _____

E-mail Address: _____

Height: _____ Weight: _____

Preferred Language: check one below ☐ English ☐ Spanish ☐ Other _____

Spouse / Parent / Guardian Information

Spouse/ Parent/ Guardian _ _____ Phone _____

Primary Care Physician _____ Physician Phone: _____ Fax: _____

Preferred Pharmacy, Location & Phone Number _____

Insurance Information

Primary Insurance Company _____ Secondary Insurance Company _____

POLICY HOLDER _____ POLICY HOLDER _____

DATE OF BIRTH _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: _____ RELATIONSHIP TO PATIENT _____

Worker's Compensation Information

Compensation Carrier _____ Claim # _____

Employer's Name _____

Address _____ City _____ State _____ Zip _____

Adjuster's Name _____ Phone _____ Date of Injury _____

Consent to Pay Insurance Benefits / Release of Medical Information

I accept responsibility for all Medical Costs incurred by the above named patient. I authorize payment of any insurance benefits to be made directly to Sonoran Orthopedic Trauma Surgeons, PLLC. I authorize the release of any medical information necessary to process all insurance claims.

_____

Signature of Patient or Insured Party if Patient is a Minor **Date**

By request, we can provide these forms in any languages listed via language line interpreting services; Spanish, Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, French Creole, French, Polish, Portuguese, Italian, German, Japanese, and Persian (Farsi).

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HEALTH QUESTIONNAIRE

(Please complete fully)

Name_____Date:_____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Occupation:_____ **Hand Dominant**: ☐ Right ☐ Left

History of Past Illnesses: Have you had:

Diabetes ☐ No ☐ Yes Heart Disease ☐ No ☐ Yes Lung Disease ☐ No ☐ Yes

Stroke ☐ No ☐ Yes Cancer ☐ No ☐ Yes Hypertension ☐ No ☐ Yes

Kidney Disease ☐ No ☐ Yes

Other Serious Illness: _____

Previous surgeries? ☐ No ☐ Yes

Please List:

_____

Have any of your blood relatives ever been diagnosed with health issues? ☐ No ☐ Yes

Relationship to yourself	Type of Disease
_____	_____
_____	_____

Do you have allergies to medications? ☐ No ☐ Yes

Please List:

_____	_____
_____	_____

Please list all medications you take on a regular basis, including Aspirin and Aspirin Containing Products:

_____	_____
_____	_____
_____	_____

Do you currently use tobacco? _____No_____Yes

Do you have an advanced care plan or designated surrogate? _____No_____ Yes

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General:

Height _____ Weight _____

Recent weight change ☐ No ☐ Yes

Skin:

Rashes ☐ No ☐ Yes

Jaundice ☐ No ☐ Yes

Other, explain: _____

Head, Eyes, Earns, Nose, Throat & Neck:

Double vision ☐ No ☐ Yes

Headaches ☐ No ☐ Yes

Seizures ☐ No ☐ Yes

Dizziness ☐ No ☐ Yes

Hard of Hearing ☐ No ☐ Yes

Thyroid Problems ☐ No ☐ Yes

Other, explain: _____

Respiratory:

Spitting up blood ☐ No ☐ Yes

Asthma / Wheezing ☐ No ☐ Yes

Difficulty breathing ☐ No ☐ Yes

Pleurisy /Pneumonia ☐ No ☐ Yes

Other, explain: _____

Cardiovascular:

Chest pain/angina ☐ No ☐ Yes

Shortness of breath ☐ No ☐ Yes

Difficulty walking (2 blocks) ☐ No ☐ Yes

Heart problems / attacks ☐ No ☐ Yes

Heart arrhythmias ☐ No ☐ Yes

High blood pressure ☐ No ☐ Yes

Heart murmur ☐ No ☐ Yes

Swelling of hands, feet ☐ No ☐ Yes

Other, explain: _____

Hematologic:

Bleeding tendencies ☐ No ☐ Yes

Anemia ☐ No ☐ Yes

Blood disease ☐ No ☐ Yes

Other, explain: _____

Gastrointestinal:

Peptic ulcer ☐ No ☐ Yes

Vomiting blood / food ☐ No ☐ Yes

Gallbladder disease ☐ No ☐ Yes

Liver Problems ☐ No ☐ Yes

Hepatitis ☐ No ☐ Yes

Painful bowel movements ☐ No ☐ Yes

Dear Patient:

Bleeding w/bowel movements ☐ No ☐ Yes

Black stools ☐ No ☐ Yes

Hemorrhoids ☐ No ☐ Yes

Recent change in bowel habits ☐ No ☐ Yes

Frequent diarrhea ☐ No ☐ Yes

Heartburn ☐ No ☐ Yes

Cramping/pain in abdomen ☐ No ☐ Yes

Does food stick in your throat? ☐ No ☐ Yes

Other, explain: _____

Genitourinary:

Frequent Urination ☐ No ☐ Yes

Burning/painful urination ☐ No ☐ Yes

Blood in urine ☐ No ☐ Yes

Kidney problems ☐ No ☐ Yes

Urinary incontinence within the past 12 months ☐ No ☐ Yes

Other, explain: _____

Locomotor-Musculoskeletal:

Varicose veins ☐ No ☐ Yes

Arthritis ☐ No ☐ Yes

Phlebitis ☐ No ☐ Yes

Other, explain: _____

Neuro-psychiatric:

Loss of consciousness ☐ No ☐ Yes

Convulsions ☐ No ☐ Yes

Fainting spells ☐ No ☐ Yes

Prior Psychiatric history ☐ No ☐ Yes

Other, explain: _____

Gynecological:

Age Periods started: _____ # of days it lasts:_____

# of pregnancies: _____ # of miscarriages:_____

Date of last pap smear: _____# of children:_____

Results: _____

Have you been treated for abnormal pap smears: ☐ No ☐ Yes

Explain treatment:

Have you ever had a pelvic infection? ☐ No ☐ Yes

Have you ever had venereal disease? ☐ No ☐ Yes

Explain:

Do you practice monthly breast exams? ☐ No ☐ Yes

_____

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This letter will be used as the acknowledgement that you have received a copy of the Notice of Privacy Practices of Sonoran Orthopedic Trauma Surgeons, PLLC .The notice describes your rights and our obligations concerning how we may use information about you and how you may have access to this information.

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices of Sonoran Orthopedic Trauma Surgeons, PLLC.

Print Name: _____

Signature _____ Date:_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____ Date of birth: _____

Provide the names of those whom you agree that information can be provided:

_____
_____
_____

For Office Use Only: ***Office Staff Initials:*** _____

Complete the following only if the patient refuses to sign the Acknowledgement:

Reasons for refusal: _____

_____

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Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Sonoran Orthopedic Trauma Surgeons, PLLC, and its affiliates to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply for such messages under my cell phone plan.

Phone number: _____

Patient, Parent, Guardian, or Authorized Representative Initials: _____

I am under no obligation to authorize Sonoran Orthopedic Trauma Surgeons, PLLC to send me text messages. I may opt-out of receiving these communications at any time by contacting the clinic using the contact information below, or by responding STOP to the text message.

I acknowledge that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Sonoran Orthopedic Trauma Surgeons, PLLC and its affiliates to the phone number that I have provided.

Patient Name: _____ **DOB: _____**

Signature: _____ Date: _____

If not signed by patient, please indicate relationship:

☐ Parent ☐ Guardian ☐ Authorized Representative

Print Name: _____

Clinic Use Only

☐ Patient declined
Date: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by Sonoran Orthopedic Trauma Surgeons, PLLC and how you can get access to this information.

Please review this notice carefully

This notice is required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your health care operations. This Notice of Privacy Practices describes how we may use and disclose PHI to carry out treatment, payment or other health care services and for other specified purposes that are permitted or required by law. This notice also describes your rights with respect to PHI. If you have any questions about this notice, please contact our office our corporate office at (916) 441-0400.

Our Responsibilities

We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our workforce and business associates, and to provide this Notice of Privacy Practices, and abide by the terms of this notice.

We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose PHI, we will also change this notice. The new notice will be posted in the clinic waiting room, and a copy may be received in writing upon request.

Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your written authorization. You have the right to revoke that authorization at any time. We are unable to take back any disclosures already made with your consent.

Your Health Information Rights

- OBTAIN A COPY OF THIS NOTICE. You will receive a copy of this notice at your first visit after its publication. Thereafter you may view a copy in our waiting room or request a copy from our staff.
- AUTHORIZATION TO USE/COPY YOUR HEALTH INFORMATION. Before we use or disclose your PHI, other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- ACCESS TO YOUR HEALTH INFORMATION. You may request a copy of your health information that Sonoran Orthopedic Trauma Surgeons, PLLC. keeps in your medical/billing records. Your request must be submitted in writing. We may charge a small fee for the costs of providing you these copies.
- AMEND YOUR HEALTH INFORMATION. If you believe the information we have about you is incorrect or incomplete, you may request that the record by amended. Please speak to your physician about this information, or call our office our corporate office at (916) 441-0400.
- REQUEST CONFIDENTIAL COMMUNICATION. You may request that when we communicate with you about your health information, we do so in a specific way (examples: at a certain mailing address or a particular phone number). We will make every reasonable effort to agree to your request.
- LIMIT USE OR DISCLOSURE OF YOUR PHI. You may request in writing, that we restrict the use or disclosure of your health information for treatment, payment, health care operations, or any emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for your services.
- ACCOUNTING OF DISCLOSURES. You may request a list of disclosures of your health information that we have made after April 14, 2003 for reasons other than treatment, payment or healthcare operations. Disclosure that we make with your written authorization will not be listed.

Example of How We May Use and Disclose PHI

- We will use PHI for treatment. Example: Information obtained by your physician, nurse or other members of our staff will be recorded in your record and used to determine the course of your medical treatment. We may also provide such information to other healthcare providers involved with your treatment.
- We will use PHI for payment. Example: A bill may be sent to you or your health insurance company. The information on or accompanying the claim may include information that identifies you, your diagnosis, procedures performed and supplies used in your treatment. In some cases information from you medical record is sent to your insurance carrier.

- We will use PHI for health care operations. Example: Sonoran Orthopedic Trauma Surgeons, PLLC may use information in your record to assess care and treatment received. This information will be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

- We will use PHI for notification. Example: Sonoran Orthopedic Trauma Surgeons, PLLC may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care or your general condition. Physicians and staff, using their best judgment, may disclose to a family member, close personal friend or any other person you identify, relevant health information to facilitate that person's ability to assist in your care or make necessary arrangements.

Other Uses and Disclosures

- Appointments: We may contact you to provide appointment reminders/changes.

- Business Associates: There are some services provided in our office through contracts with business associates, such as transcribing medical records, copy services, computer support, etc. When these services are provided by contracted business associates, so that they may perform their particular duties, we have asked them to sign a confidentiality agreement verifying they will appropriately safeguard any PHI.

- Health Related Communications: We may contact you to provide referrals or other care alternatives and services that may be of interest

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to you. Including participation in research studies. If they study provides any type of treatment, the researcher will provide explanation of benefits and risks of such treatment, and how your PHI rights are affected.

- Workers' Compensation: We may disclose your health information to the extent authorized by and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

- Coroners, medical examiners, and funeral directors: We may release PHI as necessary and consistent with applicable law to carry out their duties.

- Organ procurement organizations: Should you be an organ or tissue donor, we may disclose PHI consistent with applicable law for the purpose of tissue donation and transplant.

- Victims of abuse, neglect, or domestic violence: We may disclose your PHI to a government authority, such as a social service or protective service agency, if we reasonably believe you are a victim of abuse neglect, or domestic violence. We will only disclose this type of information to the extent required by law.

- Public Health: We may disclose PHI as required by law to public health or legal authorities charged with preventing or controlling disease, injury or disability.

- Law Enforcement/Legal Issues: We may disclose your PHI for law enforcement purposes as required by law or in response to a valid subpoena, court or administrative order.

- To avert serious threat to health or safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or other persons.

- Correctional Institution: Should you be an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

- Food and Drug Administration (FDA): We may disclose to the FDA your PHI relating to adverse events with respect to drugs, food, nutritional supplements, products and product defects, or post marketing surveillance to enable product recalls, repairs or replacement.

- Device Manufacturers: If you receive a medical device that is implanted or which is used for life support functions, we may disclose PHI as required by law to the device manufacturer for tracking/research purposes. You may refuse to authorize the disclosure of your name and contact information.

- Military and Veterans: If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We may also disclose PHI about foreign military personnel to the appropriate military authority.

- National Security and Intelligence Activities: We may disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may disclose PHI to authorized officials so they may provide protection to the President and other governmental leaders, or conduct special investigations.

- Regulatory oversight: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our government programs, and compliance with civil rights.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact our corporate office at (916) 441-0400.

If you believe we have not properly protected you privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights you may contact our office. You may also send a written complaint to the U.S. Department of Health and Human Services at the office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue, S. W., Room 509 HHH Building, Washington, D.C. 20201. Sonoran Orthopedic Trauma Surgeons, PLLC will ensure that the care you receive will in no way be affected if you file a complaint.