Advanced Orthopaedic
SURGEONS

Consent for Treatment

Consentimiento para tratamiento

Patient information información del paciente

Social Security # or Military DBN: ..... Drivers License # ..... Date of Birth: .....
De Segure Social o DBN milita — Licencia de conduor # — Fech de cumpleanos

Last name: ..... First Name: ..... Middle Initial: .....
Apellido — pnmer nombre — Inscial del Segundo nombre

Address: ..... Apt #: ..... City: ..... State: ..... Zip: .....
Direccion — # De apto — Ciudad — Estadn — Codigo Postal

Home phone: ..... Work phone: ..... Cell phone: .....
Telefono da casa — Telefono del trabajo — Telefono movil

☐ Male Masculino ☐ Female Femenino ☐ Single Soltero ☐ Married Casada Email: .....
Correo electrnico

Employer Empleador

Company: ..... Location/ Store #: .....
Nombre de Empresa — Ubicacion / Tienda #

Address: ..... Suite #: ..... City: ..... State: ..... Zip: .....
Direccion — Suite # — Ciudad — Estado — Cadigo Postal

Temp Employee: ☐ Yes Si ☐ No No Name of Agency: ..... Phone: .....
Empleado temporal — Nombre de la agencia — Telefono

Consent Consentimiento

The information provided is correct to the best of my knowledge I will not hold Agile Occupation its health provider. Its employees responsible for any errors or omissions that I may have made in completing the information on this form.

La informacion proporcionada es correcta a mi leal saber y entender. No responsibilizane a Agile Occupational Medicine, a su proveedor de servicios de salud ni a sus empleados por ningun error u amision que pueda haber cometido al completer la informacion de este formulano

Signature ..... Print Name ..... Date .....

I give permission to Advanced Orthopaedic Surgeons to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (1) physical examination, (2) medical, surgical, and diagnostic (e.g. including but not limited to x-rays, blood draws, and laboratory test) processes, treatments, and procedures: (3) administration of injections, medications and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" OR "VISs"); and (4) completion of medically appropriate tests for communicable and other diseases.

Day permiso a Advanced Orthopaedic Surgeons para realizar los siguientes servicios que los médicos y otros proveedores y asistentes no médicos puedan considerar necesarios: (1) examen físico, (2) médicos, quirúrgicos y de diagnóstico (p.E). Incluyendo pero no limitado a radiografías, extracciones de sangre y pruebas de laboratorio), procesos, tratamientos y procedimientos: (3) administración de inyecciones, medicamentos e inmunizaciones (con inmunizaciones que se produciran después de recibir cualquier declaración de información de vacunas aplicable ("VIS" O "VIS "); y (4) finalización de pruebas médicamente apropiadas para enfermedades transmisibles y otras.

Signature ..... Print Name ..... Date .....
Firma — Imprimir nombre — Fecha

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Patient Health History

Historial de salud del paciente

Patient information Informacion del paciente

Last Name: ..... First Name: .....Middle Initial: .....
Apellido Primer nombre Inicial del Segundo nombre

Date of Birth: ..... Age: ..... Sex: ☐ Male ☐ Female Evaluation Date: .....
Fecha de cumpleanos Arios Masculino Mujer Fecha de evaluacion

Reason for Visit Razon de la visitia

.....

Allergies Alergias

No known dug allergies Sin alergias medicamentosas	Reaction Reaccion
.....	.....
.....	.....
.....	.....
.....	.....

Medications Medicamentos

Dosage/Frequency Dosis/Frecuencia	No known current medications No se conocen medicamentos actuals
..... /	..... /.....
..... /	..... /.....
..... /	..... /.....
..... /	..... /.....
..... /	..... /.....

Other current medication details: Otros detalles de la medicacion actual

.....

Surgical History Historia Quirurgica

No history No historia	Date Fecha	Physician Medico	Hospital Hospital
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Additional surgery details: Detalles adicionales de la cirugia

.....

Medical History Historial medico

No significant history Nigun historial de medico	Date Fecha	Comment Comentano
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Additional medical history details: Detalles adicionales del historial medica

.....

Medication	Dosages	Medication	Dosages
7. ……		9. ……	
8. ……		10. ……	

IV: ALLERGIES: (Please circle Yes or No If Yes, please explain)

1. 1. Do you have any **MEDICATION ALLERGIES**? ☐es ☐ No Explanation: ……
2. Are you allergic to **Latex**? ☐es ☐ No Explanation: ……

V. Have you ever had or do you currently have? (Please circle Yes or No If Yes, explain)

	Yes	No		
1.	☐	☐	High Blood Pressure?	Explanation: ……
2.	☐	☐	Heart Attack?	Explanation: ……
3.	☐	☐	Chest Pain or Angina?	Explanation: ……
4.	☐	☐	Irregular Heart Beat?	Explanation: ……
5.	☐	☐	Congestive Heart Failure?	Explanation: ……
6.	☐	☐	Abnormal Electrocardiogram?	Explanation: ……
7.	☐	☐	Gastric-Esophageal Reflux-Hiatal Hernia-Ulcers?	Explanation: ……
8.	☐	☐	Recent cold-cough-sore throat?	Explanation: ……
9.	☐	☐	Asthma-Emphysema-bronchitis-breathing problems?	Explanation: ……
10.	☐	☐	Abnormal Chest X-ray?	Explanation: ……
11.	☐	☐	Diabetes?	Explanation: ……
12.	☐	☐	Yellow jaundice-hepatitis-AIDS-HIV?	Explanation: ……
13.	☐	☐	Kidney Disease?	Explanation: ……
14.	☐	☐	Abnormal bleeding problems?	Explanation: ……
15.	☐	☐	Stroke-Numbness-Weakness?	Explanation: ……
16.	☐	☐	Epilepsy-Convulsive Seizures?	Explanation: ……
17.	☐	☐	Broken bones of the back-neck-face?	Explanation: ……
18.	☐	☐	Back Trouble?	Explanation: ……
19.	☐	☐	Unusual Muscle problems-diseases?	Explanation: ……
20.	☐	☐	Unexplained fevers-heat strokes?	Explanation: ……
21.	☐	☐	Bad reactions to Anesthetics?	Explanation: ……
22.	☐	☐	Any relatives with bad reaction to Anesthetics?	Explanation: ……
23.	☐	☐	Psychological-emotional problems?	Explanation: ……
24.	☐	☐	Artificial Joints? Shoulder-Elbow-Hip-Knee	Explanation: ……
25.	☐	☐	Cancer?	Explanation: ……
26.	☐	☐	Circulation problems in limbs?	Explanation: ……
27.	☐	☐	Do you take Aspirin-Anti-inflammatories?	Explanation: ……

(i.e: Mortin-Naprosyn-Voltaren-Celebrex-Vioxx-Aleve-Advil)

If so, you are REQUIRED to stop taking these Medications at least one week to prior to any surgery

Yes No

28. ☐ ☐ Could you be pregnant? If so, How may weeks? .....
29. ☐ ☐ Do you have any other medical conditions you think your Surgeon should know about?

.....

VI. FEMALE: Last Menstrual Period? ..... /..... /.....

VII. FAMILY HISTORY: (Does or did anyone in your family ever have any of the following?)

M = Mother **F** = Father **B** = Brother **S** = Sister (Please circle)

1.	Cancer?	☐ **M**	☐ **F**	☐ **B**	☐ **S**
2.	Heart Disease?	☐ **M**	☐ **F**	☐ **B**	☐ **S**
3.	Hypertension?	☐ **M**	☐ **F**	☐ **B**	☐ **S**
4.	Alcohol Abuse?	☐ **M**	☐ **F**	☐ **B**	☐ **S**

VIII. SOCIAL HISTORY:

1. Marital Status: Married ..... Single ..... Divorced ..... Widow(er) .....
2. Who do you live with? .....
3. Do you smoke? ☐ Yes ☐ No If so, number of glasses per day-week .....
   Occasionally – Socially – Alcohol-Dependent – Recovering Alcoholic (Please circle)
4. Do you drink Alcohol? ☐ Yes ☐ No If so, number of glasses per day-week .....
   Occasionally – Socially – Alcohol-Dependent – Recovering Alcoholic (Please circle)
5. Illicit Drugs? ☐ Yes ☐ No If yes, please list: .....

Signature of Patient: ..... Date: ..... /..... /..... Time: ..... : .....

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Injury Information

Informacion sobre lesions

Patient Information

Last Name: ..... First Name: ..... Middle Initial: .....
Apellido — Primer nombre — Inicial del Segundo nombre

Date of Birth: ..... Best Phone Number: ..... Occupation: .....
Major numero de telefono

Date Last Worked: ..... Chemical/toxins involved ☐ Yes ☐ No Material Safety Data available? ☐ Yes ☐ No

Injury Information

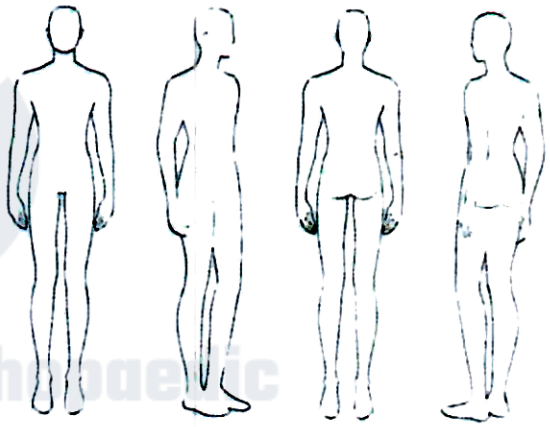
Injury Date: ..... Injury Time: ..... Injury Location: .....

How did the injury occur?

.....

.....

.....



What part of the body is injured?

.....

.....

.....

What side of the body is injured? Circle all areas to the right

☐ Left ☐ Right ☐ Both

Have you ever seen another health care provider for this injury? ☐ Yes

Name .....

Address .....

City .....

State .....

Telephone .....

Signature ..... Print Name .....Date .....

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Insurance Information

Date …….. Cell Phone …….. Home Phone ……..……

Patient Name ……..
Last Name First Name Middle Initial

Home Address ……..
Street Number Suite/Apt # City State Zip Code +4

Sex ☐ M ☐ F Age …..... DOB ……. /…..... /……. ☐ Single ☐ Married ☐ Widowed ☐ Seperated ☐ Divorced

☐ Employed ☐ Student Patient's Social Security# ……. /…..... /…..... Employer/School Name ……..……

School/Business Address …….. School/Business Phone # ……

Occupation …….. Is this a Work Related Injury? ☐ Yes ☐ No Have you filed a claim? ☐ Yes ☐ No

In case of Emergency Who Should Be Notified? …….. Phone # ……
First and Last Name/DOB/Relationship to Patient

PRIMARY INSURANCE INFORMATION

Person Responsible for Insurance …….. Relationship to Patient ……..
Last Name First Name Middle Initial

DOB/ ……..… /…….. /……. Social Security # ……. /……. /…… Occupation ……

Home Address ……..
Street Number Suite/Apt # City Sate Zip Code +4

Person Responsible Employer Name …….. Employer Phone # ……..……

Insurance Company Name …….. Address ……..……

Subscriber# Account# Policy# or Member # …….. Group# ……..……

Person Responsible for Insurance …….. Relationship to Patient ……...

SECONDARY INSURANCE INFORMATION

DOB …… /…… /…… Social Security # …… /…… /…… Occupation ……

Home Address ……..……
Street Number Suite/Apt # City Sate Zip Code +4

Person Responsible Employer Name ……..…….. Employer Phone # ……

Insurance Company Name …….. Address ……..……

Subscriber# Account# Policy# or Member # ……..…….. Group# ……..……

Advanced Orthopaedic
SURGEONS

Notice of Privacy Practices

Aviso de practicas de privacidad

The notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Este aviso describe somo su informacion medica pueda ser utilizada y divulgada y como puede acceder a esta informacion. Por favor reviselo con atencion.

Advanced Orthopaedic Surgeons at Long Beach is required by law to maintain the privacy of your Protected Health Information (PHI). Advanced Orthopaedic Surgeons at Long Beach provide clinically integrated services and consist of an organized health care arrangement. This notice describes how we will treat your PHI and how we may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. We may share your health information for treent; payment and health operations as described in this Notice. This Notice also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Advanced Orthopaedic Surgeons at Long Beach esta obligada ley a mantener la privacidad de su informacion medica protogida (PHI) AOSLB proporciona servicios dinicamente integrados y consiste en un arreglo organizado de atencion medica Este Aviso describe como trataremos su PHI y como podemos usar y divulger su PHI para llevar cabo operaciones de tratamiento, pago u atencion medica y para otros propostios que estan permitidos o requeridos por la ley Podemos compartir su informacion medica para operaciones de arbol, pagos y salud como se describe en este A viso. Este Aviso tambien describe sus derechos para accede y controlar su PHI la PHI es informacion sobre usted, incluida informacion dernograficia, que puede identificarlo y que se relaciona con su salud o condicion fisica o mental pasada, presente o future y los servicios de atencion medica relacionados.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by the physician, our office staff, and others outside of our offices that are involved in your care band treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law. We may disclosed PHI to family members, close friends or others concerned with you care and treatment.

Usos y divulgaciones de informacion medica protegida

Su PHI puede ser utilizada divulgada por el medico el personal de nuestro consultorio y otras personal fuera de nuestras oficinas que esten involucradas en su atencion y tratamiento con el fin de brindarle servicios de atencion medica, pagar sus facturas de atencion medica, para respaldar la operacion del negocio y cualquier otro uso requerido por la ley Podemos divulger su PHI a familiars amigos cercanos u otras personas interesadas en su atencion y tratamiento.

Treatment:

We will use and disclose your PHI to provide, coordinate, or mange your health care and any related services. This includes the coordination or management of your health care with a third party. For example, you PHI may be provided to a physician to whom you have been referred or are receiving treatment from to ensure that the physician has the necessary information to diagnose or treat you.

Tratamiento:

Su PHI puede ser utilizada divulgada por el medico el personal de nuestro consultorio y otras personal fuera de nuestras oficinas que esten involucradas en su atencion y tratamiento con el fin de brindarle servicios de atencion medica, pagar sus facturas de atencion medica, para respaldar la operacion del negocio y cualquier otro uso requerido por la ley Podemos divulger su PHI a familiars amigos cercanos u otras personas interesadas en su atencion y tratamiento.

Advanced Orthopaedic
SURGEONS

Notice of Privacy Practices

Aviso de practicas de privacidad

Your name and signature below indicate that you have been made aware of Advanced Orthopaedic Surgeons at Long Beach Notice of Privacy Practices (NOPP) on the date indicate. You understand that NOPP is posted in the center and a copy will be provide to you if you request it. If this is your first date of service with AOSIB please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. AOSIB

Su nombre y firma a continuacion indicant que se le ha informado sobre el Aviso de practicas de privacidad de (NOPP) en la fecha indicada Usted comprende que el NOPP esta publicado en el centro y se le proporcionara una copia si lo solicita. Si esta es su primera fecha de servico con indiquelo a la recepcion de la recepcion el/ ella le proporcionara una copia del NOPP

Name: (please print) ……..
Nombre: (en lerra de imprenta)

Signature: …… Date: ……
Firma Fecha:

ADVANCED ORTHOPAEDIC SURGEONS @ LONG BEACH, INC. PHILIP E. HILL, M.D.

1760 TERMINO AVENUE, SUITE 208, LONG BEACH, CA 90804 PHONE: 562-377-7478 FAX; 562-588-9369

Consent to Treatment And Financial Agreement

I/We hereby consent to and authorize the performance of all treatment, surgery and medical services by the staff of Advanced Orthopaedic Surgeons at Long Beach, which they may deem advisable.

I hereby certify that, to the best of my knowledge, all statements contained here on are true. I understand that I am responsible for all charges incurred by medical services for myself and for my dependence and regardless of insurance coverage.

I furthermore agree to pay legal interest, collections expense, and attorney's fees should it become necessary to assign any amount I may owe for collection.

I hereby authorized Advanced Orthopaedic Surgeons at Long Beach to release information requested by my insurance company and/or is representatives. If it becomes necessary for Advanced Orthopaedic Surgeons at Long Beach to build by insurance company for services rendered; I authorized all payments for the services to be paid directly to Advanced Orthopaedic Surgeons at Long Beach.

I fully understand that this agreement and consent will continue until cancelled by me in writing.

……..
Patient/Guardian Signature Guardian Relationship Date

……..
Witness Signature Date