William F. Sima, M.D., Inc.

322 Posada Lane, Suite A ~ Templeton, Ca 93465
Phone: 805.434.5555 ~ Fax: 805.434.5502

Thank you for scheduling an appointment with my office. I look forward to evaluating your orthopaedic condition.

Please complete this packet **PRIOR to your appointment** on: _____

TO AVOID RESCHEDULING: PLEASE arrive 15 minutes prior to your scheduled appointment and bring:

- ALL COMPLETED FORMS
- CURRENT INSURANCE CARD(S)
- PICTURE ID

ORIGIN OF PAIN

This information is required by all insurance Companies. Under the provisions of the contract with your private insurance for you and your dependent (s), liability may be an exclusion of your policy. So that your private insurance company can determine if they are correct in accepting liability for the services provided for this problem/injury, they will need the following information:

BODY PART FOR THIS VISIT: _____ ☐ RIGHT ☐ LEFT

☐ Yes ☐ No Is injury due to an automobile accident, liability accident or Workman's Compensation?

If yes, please provide the following information:

Nature of accident: ☐ Auto ☐ Workers Compensation ☐ Liability

Date of accident: _____ Claim Number: _____

Claims address (Auto/Work Comp/Liability):

_____

MEDICARE COVERAGE

FAILURE TO DISCLOSE ALL INSURANCE PLANS CAN CAUSE DENIAL/DELAY OF CLAIM PAYMENT! Medicare requires that providers determine whether Medicare is the primary or secondary payer for each claim for a Medicare beneficiary. The MSP form is used as a guide during the registration process to help identify other payers which may be primary to Medicare.

DO YOU HAVE MEDICARE COVERAGE? ☐ Yes ☐ No

If NO & and over 65, please explain why you do NOT have Medicare:

_____

If YES & under 65,

☐ Yes ☐ No Is your Medicare coverage due to disability?

☐ Yes ☐ No Are you covered by a large Employer Group Health Plan (20 or more employees) based on your own or spouse's current employer? *If yes, Medicare is secondary and primary information must be obtained*

If YES & Over 65,

☐ Yes ☐ No Are you covered by Employer Group Health Plan based on your own or spouse's current employer?
If yes, Medicare is secondary and primary information must be obtained

I CERTIFY THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE

Signature (Patient/Responsible Party) | NAME (And Relationship if not the patient) | DATE

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PATIENT INFORMATION

NAME (LAST, FIRST):		DOB:	SEX M F	HOME:
MAILING ADDRESS:		SSN:		WORK:
CITY/STATE/ZIP		MARITAL STATUS: S M D W		CELL:
PRIMARY CARE PROVIDER:	REFERRED BY:	LANGUAGE:		EMAIL:
OCCUPATION:	EMPLOYEMENT STATUS	ETHNICITY:		PREFERRED CONTACT:
EMPLOYER/SCHOOL		PHARMACY :		
EMERGENCY CONTACT NAME:		RELATIONSHIP:		PHONE:

GUARANTOR (Or person responsible for bill if different from above)

NAME (LAST, FIRST)		RELATIONSHIP TO PATIENT:		HOME:
MAILING ADDRESS:		DOB:	SEX M F	WORK:
CITY/STATE/ZIP:		SSN:		CELL:

PRIMARY INSURANCE

INSURANCE COMPANY:			
SUBSCRIBER NAME:	RELATIONSHIP TO PATIENT		
SSN	DATE OF BIRTH	SEX M F	
MEMBER ID #	GROUP #		
INSURED'S EMPLOYER	OCCUPATION		

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY			
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT		
SSN:	DATE OF BIRTH	SEX M F	
MEMBER ID #	GROUP #		
INSURED'S EMPLOYER	OCCUPATION		

- I am responsible for payment due at time of service (ie: co-pay, co-ins, ded, non-covered/denied services, and/or cash pay)
- 1.5% per month (18% per yr) interest charge and/or late fee may be added to unpaid balances over 30 days.
- $25.00 non-sufficient funds (NSF) fee will be charged for all returned checks.
- $50.00 may be charged for appointment cancelled or missed without 24 hours' notice.
- $15.00 **minimum** charge may be charged for completion of forms.
- $15.00 may be charged for providing inaccurate, outdated, and/or incomplete insurance information that result in additional billing.
- There may be a charge for copying medical records.
- I authorize payment of medical benefits to William F. Sima, MD for services provided.

Signature (Patient/Responsible Party) | Name and Relationship if not the patient | DATE

William F. Sima, M.D., Inc.

Orthopaedic Surgery, Sports Medicine and Joint Replacement

PATIENT NAME: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I hereby authorize William Sima, M.D. to obtain any and all medical records pertinent to my care from any physician, hospital, or other health care professional.

I also hereby authorize William Sima, M.D. to release any medical records belonging to them concerning my care to any physician, hospital, or other health care professional. These may include but not be limited to mental health records protected by Lanterman Pertis Short Act, drug and alcohol abuse records and HIV test results to any except as specifically follows: _____

This authorization is effective now and will be in effect for the time that I am a patient of William Sima, M.D., or until I revoke it in writing.

William Sima, M.D. reserves the right to modify the privacy practices outlined in the notice.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

A copy of the HIPPA guidelines for the office of William Sima, M.D. was made available to me to read at the front desk. Upon request a copy can be made. I understand that due to these guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, test results and chart notes.

NAME: _____ Relationship: _____ Date of Birth: _____

NAME: _____ Relationship: _____ Date of Birth: _____

NAME: _____ Relationship: _____ Date of Birth: _____

Signature (Patient/Responsible Party) | Name and Relationship if not the patient | DATE

An attempt was made to obtain an acknowledgement of receipt of the "Notice of Privacy Practices" but was not obtained because:

□ *Patient was undergoing emergency treatment* .

□ *Patient declined to sign the acknowledgement*

Name of Staff Member: _____ *Date:* _____

CONSENT TO PHOTOGRAPH/VIDEOTAPE/FILM/INTERVIEW INDIVIDUALS

I give William Sima, M.D., Inc. permission to photograph, videotape, film and/or interview myself, and to publish said photographs, videotapes, films, written testimonials and/or interviews on the internet, Dr. Sima's web site and all other forms of media. The photographs, videotapes, etc. shall constitute the exclusive property of William Sima, M.D., Inc. and may be reproduced by William Sima, M.D., Inc., without compensation or payment to the individual concerned or any other person. I also hereby release William Sima, M.D., Inc. and his employees from all claims, demands, and liabilities whatsoever in connection with the above.

Signature (Patient/Responsible Party) | Name and Relationship if not the patient | DATE

William F. Sima, M.D., Inc.

Orthopaedic Surgery, Sports Medicine and Joint Replacement

PATIENT NAME: _____ Date of Birth: _____

MEDICAL HISTORY

MEDICATION ALLERGIES

☐ CHECK HERE IF NO KNOWN MEDICATION ALLERGIES

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

CURRENT MEDICATIONS

☐ CHECK HERE IF NO CURRENT MEDICATIONS

Name of Medication	Dose	Duration

SOCIAL HISTORY

Drink alcohol? ☐ Never ☐ Social ☐ Mild ☐ Moderate ☐ Heavy

Employment? ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Work in the home
Occupation _____

Disabled? ☐ Permanent ☐ Temporary Reason for Disability_____

Exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily What type?_____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

Smoking? ☐ No ☐ Yes ☐ Former: Quit _____ Smoked _____ packs per day for ___ years

FAMILY MEDICAL HISTORY

☐ CHECK HERE IF NONE APPLY

Do any of your grandparents, parents, siblings or children have the following diseases?

	Family Member		Family Member
☐ Anemia		☐ Hypertension	
☐ Asthma		☐ Kidney Disease	
☐ Autoimmune Disorder		☐ Liver Problems	
☐ Bleeding Disorder		☐ Lung Problems	
☐ Cancer: _____		☐ Osteoporosis	
☐ Cardiovascular		☐ Rheumatoid Arthritis	
☐ Deep Venous Thrombosis		☐ Seizures	
☐ Diabetes		☐ Stroke	
☐ Heart Problems		☐ Thyroid Disease	

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PAST MEDICAL HISTORY

☐ CHECK HERE IF NONE APPLY

- ☐ Alcoholism
- ☐ Anemia
- ☐ Ankylosing Spondylarthritis
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Tendencies
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiac Catheterization
- ☐ Congenital Heart Defect
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Crohn's disease
- ☐ Deep Vein Thrombosis
- ☐ Dentures
- ☐ Depression
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy/Seizure
- ☐ Fibromyalgia
- ☐ Gastritis
- ☐ GI bleed
- ☐ Glaucoma
- ☐ Heart Valve Conditions
- ☐ Hematuria
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Incontinence
- ☐ Irritable Bowel Syndrome
- ☐ Kidney problems
- ☐ Lupus
- ☐ Migraines
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Prostate Conditions
- ☐ Pulmonary Embolism
- ☐ Rheumatoid arthritis
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

REVIEW OF SYSTEMS

☐ CHECK HERE IF NONE APPLY

- ☐ Anxiety
- ☐ Back Pain
- ☐ Bleeding Problems
- ☐ Blood in stool
- ☐ Blood in Urine
- ☐ Bruise Easily
- ☐ Chest Pain
- ☐ Chills
- ☐ Cough
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty Walking
- ☐ Difficulty with hearing
- ☐ Difficulty with Swallowing
- ☐ Dry Skin
- ☐ Elevated blood pressure
- ☐ Eye or Vision Problems
- ☐ Fever
- ☐ GERD
- ☐ Headaches
- ☐ Heart Palpitations
- ☐ Hemorrhoids
- ☐ Incontinence
- ☐ Loss of hearing
- ☐ Loss of vision
- ☐ Migraines
- ☐ Nausea
- ☐ Non Healing Wound
- ☐ Rash
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Unusual Fatigue
- ☐ Weight Change

SURGICAL HISTORY

☐ CHECK HERE IF NO PRIOR SURGERIES

	SURGERY	DATE	SIDE		SURGERY	DATE	SIDE
1.				4.			
2.				5.			
3.				6.			

Did you have any complications with surgeries or anesthesia? ☐ YES ☐ NO

If YES, Explain: _____

Hand / Wrist Evaluation
William F. Sima, M.D.

Name:_____ **Date:**_____

Are you here for your: ☐ Hand ☐ Wrist **Is it your:** ☐ Right ☐ Left **Are you**: ☐ Right handed ☐ Left handed

Your first symptoms began: ☐ Suddenly ☐ Gradually

In detail please tell us when the symptoms first started and what treatment you have had:

Previous Treatment: ☐ I have not received any treatment for this condition

I was evaluated by _____

☐ X-rays
☐ MRI
☐ Brace
☐ Physical Therapy
☐ Cortisone Injection
☐ Surgery

Nerve Conduction Study: ☐ Yes ☐ No Where? _____

Pain: (check all that apply)

☐ Aching ☐ Gnawing ☐ Throbbing
☐ Burning ☐ Sharp ☐ Dull

Pain Radiates: ☐ To the shoulder ☐ To the forearm ☐ To the thumb
☐ To the index finger ☐ To the small finger ☐ Other:_____

Swelling: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Numbness: ☐ All fingers ☐ Thumb ☐ Small finger ☐ Entire arm
☐ All fingers except thumb ☐ Index finger ☐ Whole hand
☐ First three fingers ☐ Long finger ☐ Top of hand
☐ 4th and 5th fingers ☐ Ring finger ☐ Bottom of hand

Weakness: ☐ YES ☐ NO

Difficulty with: ☐ House & yard work ☐ Driving ☐ Getting in & out of chair
☐ Gripping ☐ Sleep ☐ Getting dressed
☐ Opening jars ☐ Grasping ☐ Other: _____

Medications: ☐ Not required ☐ Used occasionally ☐ Required daily

Medications you have tried:

☐ Aleve ☐ Percocet
☐ Advil ☐ Naprosyn
☐ Tylenol ☐ Motrin/Ibuprofen
☐ Celebrex ☐ Other: _____