

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	HOME:
MAILING ADDRESS:		SSN:		WORK:
CITY/STATE/ZIP		MARITAL STATUS:		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	WORK:
CITY/STATE/ZIP:		SSN:		CELL:

PRIMARY INSURANCE

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY:			INSURANCE COMPANY		
SUBSCRIBER NAME:	RELATIONSHIP TO PATIENT		SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	
SSN	DATE OF BIRTH	SEX	SSN:	DATE OF BIRTH	SEX
MEMBER ID #	GROUP #		MEMBER ID #	GROUP #	
INSURED'S EMPLOYER	OCCUPATION		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
1.	_____
2.	_____
3.	_____

4.	<hr/>	<hr/>
5.	<hr/>	<hr/>
6.	<hr/>	<hr/>

CURRENT MEDICATIONS

CHECK HERE IF NO CURRENT MEDICATIONS

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	_____
Asthma	_____
Autoimmune Disorder	_____
Bleeding Disorder	_____
Cancer: _____	_____
Cardiovascular	_____
Deep Venous Thrombosis	_____
Diabetes	_____
Heart Problems	_____

- Hypertension
- Kidney Disease
- Liver Problems
- Lung Problems
- Osteoporosis
- Rheumatoid Arthritis
- Seizures
- Stroke
- Thyroid Disease

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Orthopaedic Surgery, Sports Medicine and Joint Replacement

PAST MEDICAL HISTORY

CHECK HERE IF NONE APPLY

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

REVIEW OF SYSTEMS

CHECK HERE IF NONE APPLY

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> GERD	<input type="checkbox"/> Non Healing Wound
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Headaches	<input type="checkbox"/> Rash
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Difficulty with hearing	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Seizures
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Difficulty with Swallowing	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Elevated blood pressure	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chills	<input type="checkbox"/> Eye or Vision Problems	<input type="checkbox"/> Migraines	<input type="checkbox"/> Unusual Fatigue
<input type="checkbox"/> Cough	<input type="checkbox"/> Fever	<input type="checkbox"/> Nausea	<input type="checkbox"/> 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: _____

Shoulder Evaluation
William F. Sima, M.D.

Name: _____ **Date:** _____

Which shoulder are you being seen for today? Right Left **Are you:** Right handed Left Handed

Your first symptoms began: Suddenly Gradually **As a result of:** A fall Tripping
 Injury MVA
 Misstep No injury

What date did your pain first begin? _____

In detail please explain how you injured yourself

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

I was evaluated by _____

X-rays at: _____ Physical Therapy Cortisone Injection Brace
 MRI at: _____ Surgery by Dr: _____

Current Symptoms:

- Feeling great
- Much better
- Somewhat better
- Same as it was
- Worse

Quality of Pain:

- No pain
- Achy
- Burning
- Dull
- Gnawing
- Itchy
- Pinching
- Pulling
- Sharp
- Throbbing

Pain Radiates to:

- Outside of upper arm
- To the mid upper arm
- To the elbow
- To the wrist
- To the thumb
- To the hand
- To the neck
- To the shoulder blade

Pain is worse with:

- Reaching over head
- Reaching out to the side
- Reaching behind back
- Reaching across chest
- Sleeping
- Lifting
- Pushing
- Sports
- Throwing
- Combing Hair
- Dressing
- Driving

Weakness:

- With overhead lifting
- With lifting
- In the shoulder

Paresthesias (Tingling):

- Elbow
- Fingers
- Forearm
- Hand
- Shoulder
- Whole Arm

Also Experiencing:

- Grinding
- Clicking
- Popping
- Cracking

Instability:

- Shoulder
- Frequent Instability
- Self Reduced instability
- Required ER care
- Dislocated

Stiffness:

- Yes
- No

Work Status:

- Full duty
- Light Duty
- Missed work since _____
- Out of work
- Unemployed
- Retired
- Disabled
- Student

PAIN:

What amount of shoulder pain have you experienced in the last week doing the following:

1. **Reaching overhead:** None Mild Moderate Severe Extreme
2. **Reaching behind back:** None Mild Moderate Severe Extreme
3. **Lifting:** None Mild Moderate Severe Extreme

FUNCTION (daily living):

4. **Showering and personal hygiene:** None Mild Moderate Severe Extreme
5. **Putting on shirt:** None Mild Moderate Severe Extreme
6. **Getting in and out of chair:** None Mild Moderate Severe Extreme

11/22/2021