Orthopedic Specialists
OF SACRAMENTO

WELCOME TO ORTHOPEDIC SPECIALISTS OF SACRAMENTO

FORMERLY SACRAMENTO KNEE & SPORTS MEDICINE!

Your appointment with Dr. _____ is scheduled for

_____ @ _____.Check in @_____

Enclosed, you will find a registration sheet, a medical history form, and our acknowledgement form. Bring these with you to your appointment, along with the requested information checked below. ***Please call to confirm at least 5 days prior to the date of your appointment or it may be cancelled***

Thank you in advance for your co-operation.

We will need to obtain a current copy of your health insurance card. If your insurance requires a referral or authorization, you must have this at the time of your appointment. ***Co-pays must be paid upon check-in.***

It is your responsibility to provide medical records and/or diagnostic films, if any. Make arrangements in advance to pick up and hand carry the following so that you will know they are here for your appointment:
Please obtain Xray/MRI on a CD.

_____ Records **_____ Xrays** **_____ EMG**
_____ MRI **_____ Arthrogram** **_____ Other:**

IF THE REQUESTED INFORMATION IS NOT AVAILABLE AT THE TIME OF CONSULTATION, YOUR APPOINTMENT MAY BE RESCHEDULED.

Please bring or wear the appropriate clothing for your exam, such as shorts for lower extremity exams, and sleeveless tops for upper extremity exams.

1111 Exposition Blvd #400A, Sacramento, CA 95815
Ph: 916.389.7977 Fx: 916.389.7951 www.orthosac.com

Masoud Ghalambor, M.D.
Arthroscopic & Reconstructive Surgery of the Foot & Ankle

Soheil A. Payvandi, D.O.
Arthroscopic & Reconstructive Surgery of the Hand, Elbow & Wrist

David W. Wang, M.D.
Arthroscopic & Reconstructive Surgery of the Knee, Shoulder & Elbow

WELCOME TO ORTHOPEDIC SPECIALISTS OF SACRAMENTO!

PLEASE FILL OUT ACCORDINGLY

LAST NAME:_____FIRST NAME:_____M.I. _____

NICK NAME:_____DATE OF BIRTH:_____SEX: _____

HOME PHONE #:_____MOBILE #: _____

HOME ADDRESS: _____

CITY:_____STATE:_____ZIP CODE: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING DOCTOR: _____

EMPLOYER: _____

OCCUPATION:_____WORK #: _____

WORK ADDRESS: _____

SOCIAL SECURITY #:_____-____-_____EMAIL: _____

INSURANCE INFORMATION PLEASE PUT N/A IF NOT APPLICABLE

PRIMARY INSURANCE:_____ID#: _____

SECONDARY INSURANCE:_____ID#: _____

PLAN HOLDER NAME:_____DOB:_____SEX: _____

WORKERS COMPENSATION PLEASE PUT N/A IF NOT APPLICABLE

DATE OF INJURY: _____ CLAIM #: _____

CARRIER NAME: _____

EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____

PHONE #:_____RELATIONSHIP: _____

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PATIENT ACKNOWLEDGEMENT

Patient Name: _____

- **My signature constitutes assignment of benefits for services performed by the providers of Orthopedic Specialists of Sacramento; a photocopy of this assignment is considered as valid as the original. Orthopedic Specialists of Sacramento may release information that may be necessary to secure payment from my insurance. I understand that I am financially responsible for claims that are denied or delayed by my insurance, and that co-pays and/or deductibles are due at the time of service.**

- **The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at: https://openpaymentsdata.cms.gov**

- **I have elected not to use any/all of my insurance coverage for this visit, including but not limited to, those services that require prior authorization, and I am accepting financial responsibility for services rendered.**

- **I acknowledge I have access to, reviewed, or received a copy of Orthopedic Specialists of Sacramento Notice of Privacy Practices**

- **Worker's Compensation: I understand that the providers of Orthopedic Specialists of Sacramento provide treatment and reporting in compliance with the State of California Labor Code.**

Date: _____/_____/_____ **Signature: _____**

If patient is a minor, relationship to patient: _____

Orthopedic Specialists of Sacramento

PLEASE COMPLETE THIS FORM

Please bring this form with you to your appointment. We will be providing you with an additional health history questionnaire upon arrival for your appointment.

Are you currently taking any medications? Yes* No

Medication	Dosage	Frequency	Reason

***Please obtain a complete list from your pharmacy with all information.**

Pharmacy: _____ Phone Number: (_____) _____-_____

Do you have any allergies to any medications? Yes No

Name of Medication	Symptoms (such as "penicillin causes a rash")

Do you have an allergy to latex? Yes No

Have you ever been diagnosed with sleep apnea? Yes No

If YES, do you use a CPAP? Yes No

Have you ever been seen by a Cardiologist? Yes No

If YES, by Dr._____ When: _____

Have you ever had a blood clot or DVT? Yes No

Have any family members ever had a blood clot or DVT? Yes No

Please list any prior surgeries below; use additional white paper if necessary.

Date	Surgery

Patient Signature:

_____ Date: _____/_____/_____

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ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD

Today's date Mth Day

Last name **First name** **MI**

CHIEF COMPLAINT: ○ Right ○ Left _____

What is your Dominant Hand? ○ Right ○ Left

ONSET OF SYMPTOMS?					
○	Unknown	○	Gradually	○	Suddenly, without injury
○	After an Injury	Date of Injury :			

HOW CAN THE CURRENT PROBLEM BE CHARACTERIZED?					
○	Intermittent	○	Constant	○	Burning
○	Dull	○	Sharp	○	Stabbing
○	Throbbing	○	Aching	○	Cramping
○	Pressure	○	Radiating	○	Numbness / Tingling

ARE THE SYMPTOMS WORSE DURING THE DAY OR NIGHT?					
○	No difference	○	Day	○	Night
○	With Activities	○	At Rest		

HOW LONG HAVE THE SYMPTOMS BEEN PRESENT?				
	DAYS	WEEKS	MONTHS	YEARS
1	○	○	○	○
2	○	○	○	○
3	○	○	○	○
4	○	○	○	○
5	○		○	○
6	○		○	○
7			○	○
8			○	○
9			○	○
10			○	○
11			○	○

ON THE SCALE BELOW, MARK THE SEVERITY OF THE PAIN, 10 BEING THE HIGHEST

None			Mild				Moderate					Severe									
○	0	○	1	○	2	○	3	○	4	○	5	○	6	○	7	○	8	○	9	○	10

WORK RELATED INJURY?			
○	No	○	Yes, If Yes please answer the questions below.

ARE YOU CURRENTLY RECEIVING MEDICAL TREATMENT FOR THIS INJURY? ○ No ○ Yes

ARE YOU CURRENTLY WORKING? ○ No ○ Yes ○ Regular Work ○ Modified Work

DATE LAST WORKED? _____

PRIOR TREATMENT/TESTING?		○	No	○	Yes, If Yes please indicate the prior treatment / testing		
○	Surgery	○	EMG	○	X-Rays	○	PT
○	Injections	○	MRI	○	Pain Meds / Other	○	Chiropractor
	Other: Treatments:						

Review Of Systems - Please answer Yes or No to the following:

CONSTITUTIONAL SYMPTOMS	Yes	No
Fever	○	○
Chills	○	○
Headache	○	○

EYES	Yes	No
Blurred Vision	○	○
Double Vision	○	○
Pain	○	○
Glasses	○	○

ENDOCRINE	Yes	No
Excessive thirst	○	○
Too hot/cold	○	○
Tired/sluggish	○	○
Thyroids	○	○
Diabetes	○	○

GENITOURINARY	Yes	No
Difficulty urinating	○	○
Blood in urine	○	○
Urinary frequency	○	○
Loss of bladder control	○	○

RESPIRATORY	Yes	No
Asthma attack	○	○
Frequent cough	○	○
Shortness of breath with activity	○	○

GASTROINTESTINAL	Yes	No
Abdominal Pain	○	○
Nausea/Vomiting	○	○
Rectal Bleeding	○	○
Loss of bowel control	○	○
Ulcers	○	○

NEUROLOGICAL	Yes	No
Tremors	○	○
Dizzy spells	○	○
Numbness/Tingling	○	○
Stroke	○	○
Parkinson's	○	○

CARDIOVASCULAR	Yes	No
Myocardial infarction	○	○
Leg swelling or edema	○	○
High blood pressure	○	○

HEMATOLOGIC/LYMPHATIC	Yes	No
Swollen glands	○	○
Blood clots (DVT)	○	○
Other Bleeding problems	○	○
Leg swelling or edema	○	○

PSYCHOLOGICAL	Yes	No
History of depression	○	○
History of anxiety	○	○
History of bipolar	○	○
History of schizophrenia	○	○

EAR/NOSE/THROAT/MOUTH	Yes	No
Ear infection	○	○
Sore throat	○	○
Sinus problems	○	○
Dental problems	○	○

INTEGUMENTARY	Yes	No
Skin rash	○	○
Boils	○	○
Persistent itch	○	○

MUSCULOSKELETAL	Yes	No
Osteoarthritis	○	○
Rheumatoid Arthritis	○	○
Neck pain	○	○
Back pain	○	○
Use of cane or crutch	○	○

NEUROLOGICAL (CONTINUED)	Yes	No
Seizures	○	○
Difficulty standing	○	○
Difficulty walking	○	○
Difficulty with balance	○	○
Weakness	○	○

○	Other - Print Below

Current Medical Conditions: PLEASE INDICATE ANY THAT YOU HAVE / HAD:

○	Diabetes	○	High Blood Pressure	○	Heart Disease	○	High Cholesterol
○	Heart Attack	○	Stroke	○	Pacemaker	○	Vascular Disease
○	Hyper-Thyroid (over-active)	○	Hypo-Thyroid (under-active)	○	Rheumatoid Arthritis	○	Stomach Ulcers
○	Gout	○	Depression	○	Pneumonia	○	Asthma
○	Cancer	Type: _____					
○	Other	_____					

Family History

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?						
FATHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Blood Clots/DVT	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Blood Clots/DVT	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Blood Clots/DVT	○ Rheumatoid Arthritis

Social History

DO YOU SMOKE TOBACCO? ○ Yes, Current Smoker ○ No, Never Smoked ○ Previously Smoked

If yes, how many packs per day? ○ Less than one pack ○ One pack ○ Two packs ○ Three + packs

How many years have you smoked? ○ 1-5 years ○ 6-10 years ○ 11-20 years ○ 20 + years

If you previously smoked, how long has it been since you quit smoking? _____ years

If yes, how many years did you smoke before you quit? _____ years

DO YOU DRINK ALCOHOL? ○ Yes ○ No

If yes, how frequently do you drink? ○ 1x week ○ 2x week ○ 3x week ○ More than 3x week

DO YOU HAVE A HISTORY OF RECREATIONAL DRUG USE? ○ Yes ○ No ○ Prior use

DO YOU DRINK CAFFEINATED BEVERAGES? ○ No ○ Yes

If yes, how many per day? ○ 1-2 cups/cans ○ 3-4 cups/cans ○ 5+ cups/cans

DO YOU LIVE ALONE? ○ No ○ Yes Who do you live with? ○ Spouse ○ Family ○ Friend

PATIENT SIGNATURE:

_____ **DATE:** _____