

# PATIENT INFORMATION FORM

<b>PATIENT INFORMATION</b>					
Patient Name Last		First		Date of Birth	Age
Street Address				<input type="checkbox"/> Male	<input type="checkbox"/> Female
City		State		Zip Code	
				Social Security Number	
Home Phone			Work Phone		
Employer Name		Occupation		Work Injury?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				Accident/Injury?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Family Physician					
Address of Family Physician				Phone Number of Family Physician	
Who Referred You To Our Office?					
<input type="checkbox"/> Family Physician <input type="checkbox"/> Other Physician _____ <input type="checkbox"/> Friend <input type="checkbox"/> Insurance Company <input type="checkbox"/> Lawyer <input type="checkbox"/> Other _____					
Have You Been Seen By Any Physician In This Practice Before?					
<input type="checkbox"/> No <input type="checkbox"/> Yes					
Emergency Contact Name		Relationship		Home Phone Number	
				Work Phone Number	
<b>HISTORY OF PROBLEM</b>					
Please Explain Briefly Why You Are Seeing The Doctor. <i>(Specify LEFT or RIGHT)</i>					
First Symptom OR Date of Injury.					
How Did Injury Occur & When?					
<b>INSURANCE INFORMATION</b>					
<i>(Please Present Insurance Cards to Receptionists)</i>					
Subscriber Name					
Primary Insurance Company			Secondary Insurance Company		
I.D. Number			I.D. Number		
Group Number			Group Number		
<input type="checkbox"/> <i>Check here if you believe Worker's Compensation is responsible for payment</i>					
<b>RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS</b>					
I hereby authorize ROGER A. MANN, MD., INC., JEFFREY A MANN, M.D., and/or SARA EDWARDS, M.D. to release informatics regarding my treatment or examination rendered to me for medical or surgical care to insurance company (s) or its representatives. I also authorize payment to be made directly to ROGER A. MANN, M.D., INC., JEFFREY A MANN, M.D., and/or SARA L. EDWARDS, M.D., in the amount due for all medical and/or surgical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company (s). Furthermore, I authorize ROGER A. MANN, M.D., INC., JEFFREY A. MANN, M.D., and/or SARA L. EDWARDS, M.D. to obtain my medical records from any necessary hospital, clinic, or doctor's office.					
SIGNATURE X				DATE	

## PATIENT HEALTH QUESTIONNAIRE

Patient's Name: \_\_\_\_\_

### ALLERGIES AND SENSITIVITIES

Have you experienced any reaction following the administration of:

Penicillin or other antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Morphine, Codeine, Demerol, or other narcotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Aspirin or other pain medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Sulfur Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tetanus Antitoxin or other serums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Adhesive tape or surgical tape	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Any foods (i.e. eggs, milk, chocolate, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

### MEDICATIONS:

Please indicate all medications, vitamins, and/or herbs you take regularly. Check bottle label for the dose and frequency that you take the medications, vitamins, and/or herbs:

**Example: Pepcid 20mg 1 pill 2 times a day.** Please attach additional sheets if necessary.

Have you ever had any surgeries? <i>(Please list on separate sheet)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you been hospitalized within the last year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have there been any changes in your medical condition within the last year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you been treated for a medical condition in the last year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you received any blood transfusions?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever had an infection in an incision after surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever had problems with anesthesia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you or a family member ever had a bleeding problem after surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### SOCIAL HISTORY

Marital Status:     Single     Married     Divorced     Widowed     Other

Height \_\_\_\_\_ Weight \_\_\_\_\_

Is there anyone at home able to take care of you?     Yes     No

Have you used any of the following substances?  
**Tobacco**                             Never     Previously, but I quit     Currently Frequency

**Alcohol: beer, wine, liquor**     Never     Rarely     Weekly     Daily

### PERSONAL HISTORY

Please answer YES or No to ALL questions below.

1. Heart condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. Tumor or cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Kidney Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	11. Arthritis, gout, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	12. Fractures, sprains or dislocations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Bleeding problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	13. Painful or swollen joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	14. Bursitis or Neuritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Blood/Circulation Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. Bone Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16. Muscle weakness or atrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Clots in legs or vein problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	17. Excessive fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered YES to any question above, please explain in detail. If you require more space please use a separate sheet.

OAKLAND BONE & JOINT SPECIALISTS

ROGER A. MANN, M.D.

JEFFREY A. MANN, M.D.

SARA L. EDWARDS, M.D.

ORTHOPAEDIC SPECIALISTS

80 Grand Ave., Fifth Floor, Oakland, CA 94612 / (510) 451-6266 FAX (510) 451-6260

CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the following is offered for your information and consent. Please be aware that it is office policy to require your reading and signing of this form prior to the provision of treatment or any other medical services.

Patient's Name \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have a right:**

- To object to the use of my health information for care coordination purposes.
- To request restrictions as to how my health information may be used or discloses to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken in.
- Of reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_

If you would like to read more about HIPAA rules and regulations ask the office staff and they can provide more information for you to read.

OFFICE USE ONLY:     \_\_\_Accepted \_\_\_Denied

Signature of Patient or Legal Representative & Date:

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Office Staff, Date

**Oakland Bone & Joint Specialists**  
**ROGER A. MANN, M.D.**  
**JEFFREY A. MANN, M.D.**  
**SARA L. EDWARDS, M.D.**

**APPOINTMENT DATE AND TIME:** \_\_\_\_\_

**THERE WILL BE A \$25 NO SHOW FEE FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS**

**PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:**

- Your insurance information, Photo ID and Copay
- Any pertinent x-rays, MRI's, etc.
- A Referral (if one is required by your insurance)
- The attached forms

**DIRECTIONS TO THE OAKLAND OFFICE:**

**80 Grand Ave, Fifth Floor Oakland, Ca. 94612**

**(corner of Grand and Broadway)**

**(510) 451-6266**

**When approaching from Orinda, Lafayette & Walnut Creek via the 980 Freeway (Hwy 24 through the Caldecott Tunnel):**

Take the 27<sup>th</sup> Street / West Grand Avenue exit. At the bottom of the ramp, make a left turn onto 27<sup>th</sup> Street. Follow 27<sup>th</sup> Street to Broadway & make a right turn onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

**When approaching from the East on Interstate 580 (from San Leandro):**

Take the Harrison Street / MacArthur Blvd. exit. The ramp becomes MacArthur without making a turn. Follow MacArthur to Broadway & make a left onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

**When approaching from the West on Interstate 580 (from San Francisco, Berkeley & the North Bay):**

Take the Webster Street / Broadway exit. The exit will offer two choices – take the left hand option of the exit to Broadway South. Make a right turn onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

**When approaching from the South on Interstate 880 (from Alameda):**

Take the Broadway exit. At the bottom of the ramp, make a right hand turn onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

**There is a parking lot attached to the building but it is privately owned so there is a fee for parking.**

**\*Dr. Roger Mann patients please note:** Due the nature of our specialized practice, extended waiting periods may occur. We apologize in advance for any inconvenience. We are trying to provide the best medical care for each individual patient. Thank you for your understanding regarding this concern.