Peter T. Simonian, M.D.
Board Certified Orthopaedic Surgeon
Orthopaedic Sports Medicine Fellowship

729 N. Medical Center Drive West, Suite 101
Clovis, CA 93611

Telephone: 559-439-7633
Fax: 559-439-7631

Patient's Name: ____

We have you scheduled for an appointment on:________________________________

Enclosed you will find New Patient Registration forms for your upcoming appointment at Simonian Sports Medicine Clinic. Please take a moment to complete the forms and bring them with you to your appointment.

Also, please remember to bring:

- Your insurance card(s)
- Any co-payment due required by your insurance
- X-ray/MRI films (if any) which were recently taken of the area injured.

Please plan to arrive 15 minutes prior to your scheduled appointment time.

Thank you and we look forward to meeting you.

Simonian Sports Medicine Clinic

SIMONIAN Sports Medicine CLINIC
A Medical Corporation
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & A PART OF SANTÉ HEALTH FOUNDATION

Patient Registration

Approx. Date of Injury

PATIENT INFORMATION

Last Name	First Name	Middle Name

Date of Birth	Sex	Social Security #	Marital Status	Age
	☐ M ☐ F	- -	☐ Single ☐ Widowed ☐ Separated ☐ Married ☐ Divorced	

Home Street Address	City and State	Zip Code
Mailing Street Address	City and State	Zip Code

Home Phone	Cell Phone	Drivers License #	Exp Date
( ) -	( ) -		

Employer or School	Address	Occupation

Emergency Contact Person	Emergency Contact's Phone
	( ) -

RESPONSIBLE PARTY (If not Patient)

Last Name (Responsible Party)	First Name	MI	Social Security #
			- -

Mailing Street Address	City and State	Zip Code

Employer Name	Address	City and State	Zip Code

Cell Phone	Occupation	Drivers License
( ) -		

SPOUSE (If not Responsible Party)

Spouse's Last Name	First Name	MI	Social Security #
			- -

Spouse's Employer	Address	City and State	Zip Code

Cell Phone	Occupation	Drivers License
( ) -		

PRIMARY INSURANCE

Subscriber's Name on Card	Insurance Company	Subscriber #	Group Number
Insurance Company Street Address	City	State / Zip Code	Date of Birth

SECONDARY INSURANCE

Subscriber's Name on Card	Insurance Company	Subscriber #	Group Number
Insurance Company Street Address	City	State / Zip Code	Date of Birth

REFERRING PHYSICIAN(S)

Primary Care Physician	Referring Physician
Primary Care Physician's Address	Referring Physician's Address
Primary Care Physician's Telephone Number	Referring Physician's Telephone Number

PHARMACY

Name of Pharmacy	Address or Cross Streets	Telephone Number

INDUSTRIAL OR ON THE JOB INJURY? PLEASE CIRCLE ONE → NO YES (IF **YES**, PLEASE COMPLETE BELOW)

Labor & Industries Claim Number	Last Day Worked	Commercial Insurance Carrier
Date & Cause of Injury	Affected Area	Legal Case? ☐ YES ☐ NO

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Current Problem and Medical History

Patient's Name	Today's Date

SOCIAL HISTORY

Patient's Age	Gender ☐ Male ☐ Female	Occupation	Sports/Exercises/Hobbies

Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated	Highest Level of Education ☐ High School ☐ College ☐ Graduate School
Do You Smoke? ☐ No ☐ Yes How Much Per Week? ______	Drink Alcohol? ☐ No ☐ Yes How Much Per Week ______
Have You Had Chemical Dependency? ☐ No ☐ Yes, when?	Any Intravenous Drug Use? ☐ No ☐ Yes, when?

HISTORY OF PRESENT INJURY OR PROBLEM

1 Briefly describe your bone or joint problem and for what you would like help:

2 Injury — Is your problem related to an injury? ☐ Yes ☐ No
Briefly describe how and where it occurred ______

3 Location — Where is your condition/problem? ☐ Right Shoulder ☐ Right Knee ☐ Right Arm ☐ Right Leg ☐ Left Shoulder ☐ Left Knee ☐ Left Arm ☐ Left Leg ☐ Other ______

4 Quality — Are you experiencing? ☐ Pain ☐ Weakness ☐ Swelling ☐ Color Change ☐ Numbness ☐ Tingling
What type of pain do you have? ☐ Dull ☐ Sharp ☐ Tightness ☐ Radiating

5 Severity — How strong is your pain? ☐ Light ☐ Moderate ☐ Severe
How bothersome is the problem? ☐ Interferes with Daily Activity ☐ Keeps You Up at Night
☐ Stops you from attending Work, School or Sports

6 Duration — How long has your problem lasted? ____ Days ____ Weeks ____ Months ____ Years

7 Timing — How does your pain/problem occur? ☐ Gradual Onset ☐ Intermittent ☐ Continual
Has the problem changed recently? ☐ Yes ☐ No
Have you had similar problems in the past? ☐ Yes ☐ No

8 Context — When does the pain/problem occur? ☐ Moving ☐ Lifting ☐ During Sports ☐ Other

9 + Factor — What makes the problem better? ______

10 - Factor — What makes the problem worse? ______

11 Associated — Have you had any related problems? ______

12 **PREVIOUS TEST(S) OR EXAM(S):** Please list all previous tests performed for this problem

TEST	DATE PERFORMED	TEST	DATE PERFORMED
☐ MRI	______	☐ Bone Scan	______
☐ EMG	______	☐ Arthrogram	______
☐ X-ray	______	☐ Myelogram	______
☐ CAT Scan	______	☐ Other	______
☐ Seen Another Specialist	______		

13 **IS YOUR INJURY/PROBLEM WORK OR JOB RELATED?** ☐ **NO** ☐ **YES**, Please Complete Below

Who is your Job Related Primary Physician?
What are the specific job duties effected by your injury or problem?

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Medical History Continued

PAST MEDICAL HISTORY

1 **ANY PAST SURGERIES OR HOSPITALIZATIONS?** ☐ **NO** ☐ **YES,** Please List Below

Type of Surgery/Hospitalizations	Date	Surgeon/Physican	Was it Helpful?
1			☐ Yes ☐ No
2			☐ Yes ☐ No
3			☐ Yes ☐ No
4			☐ Yes ☐ No

2 **MEDICATIONS THAT YOU TAKE**

List All Medications Taken for this Problem:

1	4
2	5
3	6

List All Other Prescription or Nonprescripton Medications

1	5
2	6
3	7
4	8

3 **LIST ANY ALLERGIES** to Any Medications or Substances

LIST ANY ALLERGIES to Any Medications or Substances	Type of Reaction

4 **BLOOD & INFECTION HISTORY**

Do you now or have you recently taken "blood thinning" medication"? (Coumadin, Aspirin) ☐ Yes ☐ No

Have you ever had any problems with previous surgeries with excessive bleeding, clots or infections? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Have you, your mother, father, or siblings ever had treatment for?

	Yourself? (Please Circle)		Family Member? (Please Circle)	
Asthma	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Heart Problems	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Liver Disease/Hepatitis	Yes	No	Yes	No
Anxiety or Depression	Yes	No	Yes	No
Sexually Transmitted Disease	Yes	No	Yes	No
Bone or Joint Problems	Yes	No	Yes	No
Pneumonia	Yes	No	Yes	No
Seizures	Yes	No	Yes	No
Thryroid Gland Problem	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No
Lung Disease	Yes	No	Yes	No
Digestive Disorders	Yes	No	Yes	No
Other Illnesses				
____________	Yes	No	Yes	No
____________	Yes	No	Yes	No

Do you have any other concerns?

Patient's Signature	Todays Date
X	

Peter T. Simonian, MD	Todays Date
X	

Patient Consent

Appointment Date

(For English Speaking)

CONSENT

I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent of such treatment. I hereby give consent of release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action I shall be responsible for any legal fees incurred.

Patient or Responsible Party Signature	Date

AUTHORIZATION

I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

Patient or Responsible Party Signature	Date

(For Spanish Speaking Only)

Español

CONSENTIMIENTO

Por medio de la presente autorizo al médico en turno que me de tratamiento médico y quirurgico, o como representate, autorizado por el paciente para ser su agente general en estos tramites medicos, doy permiso para el mismo tratamiento. Asi mismo, otorgo el necesario consentimiento para que mis registros medicos sean liberados ha personal médico ya sea necessario para el tratamiento recivido. Entiendo que seré responsable por todos cargos monetarios incurridos por el establecimiento médico indicado arriba. En caso de que mi cuenta médica sea transferida a una agencia de cobranza, yo seré responsable por los cargos legales.

Firma de Paciente o Persona Responsable	Fecha

AUTORIZACION

De acuerdo con las condiciones de mi poliza sobre servicios médicos recividos, autorizo el pago directo al médico que me atendio con sus servicios médicos o quirurjicos. Al igual, en casos que sean necesarios, doy consentimiento para que mi historia médica sea revisada por personal financiero o medico para completar las facturas para recibir mis beneficios.

Firma de Paciente o Persona Responsable	Fecha

Notice of Privacy Practices and CCR 1355.4 Compliance

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Simonian Sports Medicine Clinic. I also understand that Medical doctors are licensed and regulated by the Medical Board of California. The Medical Board may be reached by phone at (800) 633-2322 or email at www.mbc.ca.gov.

____
Name of Patient or Personal Representative

_______________________________________ ______________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority

Notice to Patients

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

____
Name of Patient or Personal Representative

_______________________________________ ______________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority

NOTICE OF PRIVACY PRACTICES

THIS 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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or other health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all protected health information that we maintain. Upon your request we will provide you with a copy of our revised notice by calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

I. Permitted Uses and Disclosures of Protected Health Information

- Treatment: Your physician will use or disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or a laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

- Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include activities that your health plan may undertake before it approves or pays for health care services that we recommend for you. These activities include: determining eligibility, reviewing services for medical necessity, and utilization review activities.

- Health Care Operations: We may use or disclose your protected health information to support the business activities of our office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the front desk where you will be asked to sign your name and indicate your physician, we may call you by name in the waiting room when your physician is ready to see you, or we may use your information as necessary, to contact you to remind you of an appointment, and leave voicemail messages on your phone or message with person answering your phone.

II. Uses and Disclosures Based on Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke an authorization, at any time, in writing, except to the extent we have relied on the use or disclosure of protected health information indicated in the authorization.

III. Permitted Uses and Disclosures Without Your Authorization or Opportunity to Object

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs and medical devices.

Communicable Diseases: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Healthy Oversight: We may be required to disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to a subpoena or administrative tribunal (to the extent such disclosure is expressly authorized).

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. For example, to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes or to determine the cause of death; to a funeral director, as authorized by law, to aid in burial; or to organizations that handle organ and tissue donations.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: We may use or disclose your protected health information to prevent a serious threat to health or safety.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Business Associates: We may disclose your protected health information to third party "business associates" who perform health care operations for us and who agree to keep your health information private.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

IV. Patient Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request access or a copy of your protected health information. You may request access and/or a copy of your medical information maintained in our records, including medical and billing records. Your request must be in writing. Following is our fee schedule for copying medical records:

Patient Request: $15-$30 per copy of record, depending on chart size

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We do not have to agree to the request, however if we do, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. You may request a restriction by completing a "Restriction Request Form" available at the front desk. You will receive a response in writing within seven (7) days of receiving your request.

Your physician may deny the restriction request if he/she believes it is in your best interest to permit the use and disclosure of your protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office manager.

You have the right to request an amendment to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us from which we may prepare a rebuttal. We will provide you with a copy of any such rebuttal. Please fill out an "Amendment Request Form" available at the front desk if you would like to request that an amendment be made to your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or pursuant to a valid authorization as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Central California Health Information Exchange. We participate in the Central California Health Information Exchange (the "Exchange"), which is an electronic health record that is shared with other health care providers who participate in the Exchange and, in other certain limited circumstances, with other health care providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for health care providers to access when it is determined that you require emergent care.

V. Complaints

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact our Corporate Privacy Officer, Juan Carlo Muro at (559) 228-5479 or by e-mail at JCMuro@santehealth.net. You may also send a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights as follows:

U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Regional Manager
50 United Nations Plaza, Room 322
San Francisco, CA 94102
1-415-437-8310

Simonian Sports Medicine Clinic will ensure that you will not be penalized nor will the care you receive at our facilities be impacted if you file a complaint.

This notice was published and becomes effective on April 14, 2003.

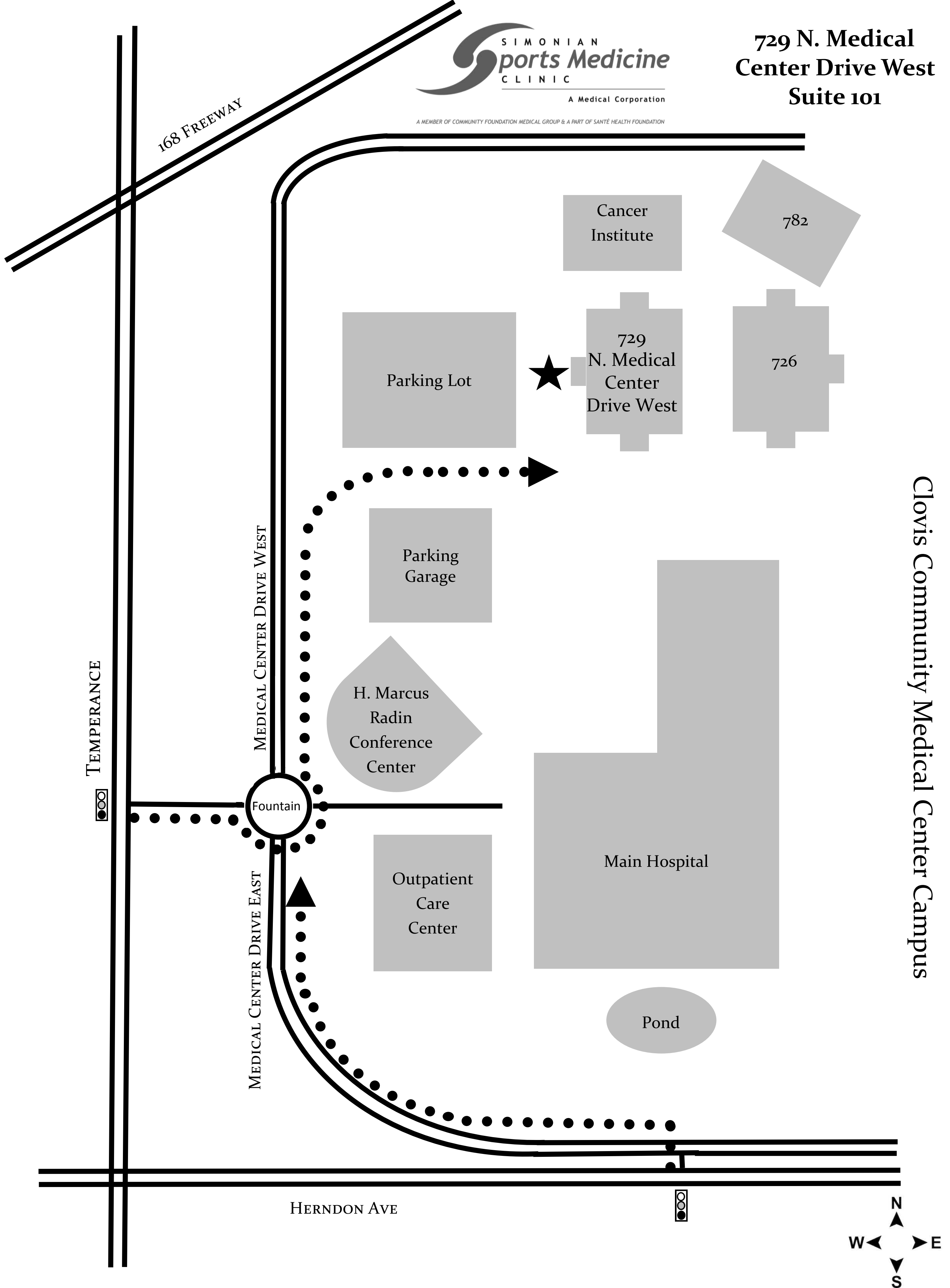
Notice of Open Payments Database

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.

____
Name of Patient or Personal Representative

______________________________________ ____________________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority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Medical Center Drive West
Temperance
H. Marcus Radin Conference Center
Fountain
Main Hospital
Outpatient Care Center
Medical Center Drive East
Pond
Herndon Ave
N
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