William F. Sima, M.D., Inc.~Orthopaedic Surgeon
Jennifer Costanzo, P.A.

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

Welcome,

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

As a new patient I need your assistance with the information that will be used to establish your account and medical chart. Attached is paperwork for you to complete PRIOR to your appointment. If a question does not apply to you, write N/A (not applicable) in the appropriate space.

TO AVOID RESCHEDULING PLEASE BRING THE FOLLOWING ITEMS FOR YOUR INITIAL APPOINTMENT:

- PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT
- ALL COMPLETED FORMS SENT TO YOU FROM OUR OFFICE
- CURRENT INSURANCE CARD(S)
- PICTURE ID

MEDICATION REFILL POLICY: I am often out of the office due to my surgical schedule. Please allow 72 hours for refill requests to be processed. If you need a refill on an existing prescription, please call your pharmacy and they will fax a request to our office.

I appreciate your effort and assistance.

Sincerely,

William F. Sima, M.D.

William F. Sima, M.D. Orthopaedic Surgeon
322 Posada Lane, Ste A
Templeton, CA 93465-4003
(805)434-5555

PATIENT INFORMATION (REQUIRED)			
NAME (LAST, FIRST)			
PHYSICAL ADDRESS (ADDR WHERE YOU CURRENTLY RESIDE)		CITY, STATE, ZIP	
MAILING ADDRESS (ADDR WHERE YOU RECEIVE YOUR MAIL)		CITY, STATE - ZIP	
HOME	WORK	CELL	EMAIL(Responsible Party) (I do not wish to receive updates: _______)
SSN	DOB	SEX **M F**	Marital Status **S M D W**
EMPLOYMENT STATUS (CIRCLE ONE) F/T P/T Retired Disabled Other _____________		EMPLOYER NAME **OR** SCHOOL (IF STUDENT)	OCCUPATION
PRE RETIREMENT EMPLOYER/OCCUPATION		PRIMARY MD	REFERRING MD

FINANCIALLY RESPONSIBLE PARTY INFORMATION (PERSON **"LEGALLY"** RESPONSIBLE TO PAY)			
NAME	RELATIONSHIP TO PATIENT	SSN	DOB
MAILING ADDRESS		CITY, STATE - ZIP	
HOME	WORK	CELL	

PRIMARY INSURANCE (REQUIRED)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER	OCCUPATION		
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX **M F**
ADDRESS OF INSURED	CITY	STATE	ZIP	

SECONDARY INSURANCE (IF APPLICABLE)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER	OCCUPATION		
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX **M F**

EMERGENCY CONTACT		
NAME	PHONE #	RELATIONSHIP

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 appointments 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.

_______________________________ _______________________
Patient/Responsible Party Signature Date

WILLIAM F. SIMA , MD, INC.
322 POSADA LANE, STE. A
TEMPLETON, CA 93465
805-434-5555

PATIENT NAME: ______________________________**DATE**: _______________

Dr. Sima is **required by federal regulations to request the following demographic information:**

ETHNICITY: (PICK ONLY ONE)	**RACE:** (PICK ONLY ONE)
___ Hispanic or Latino	___ American Indian or Alaska Native
___ Not Hispanic or Latino	___ Asian
	___ Indian
	___ Cambodian
	___ Chinese
	___ Japanese
	___ Korean
	___ Laotian
	___ Vietnamese
	___ Black or African American
	___ Native Hawaiian/Other Pacific Islander
	___ Filipino
	___ Guamanian
	___ Samoan
	___ White
	___ Other Race
___ Unknown	___ Unknown
___ Unreported/Refused	___ Unreported/Refused

PREFERRED LANGUAGE: ____ English ___ Spanish ___ Other: _______________

William F. Sima, M.D.
Medicare Coverage Information

DO YOU HAVE MEDICARE COVERAGE? **□ Yes** **□ No If "NO" & 65 or over, please explain why you do not have Medicare: ____**

(FAILURE TO DISCLOSE ALL INSURANCE PLANS CAN CAUSE DENIAL/DELAY OF CLAIM PAYMENT!)

This form must be completed by patients with Medicare coverage (primary or secondary)

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.

- Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation?
  □ Yes □ No

  If yes, please provide the following information:
  Date of accident; ________/________/________
  Nature of accident: □ Auto □ Workers Compensation □ Liability
  Claims address (Auto/Work Comp/Liability): ____
  ____

  Claim Number: ____

- If under age 65, is your Medicare coverage due to disability? □ Yes □ No

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

- If 65 and over, are you covered by Employer Group Health Plan based on your own or spouse's current employer? □ Yes □ No
  (if yes, Medicare is secondary and primary information must be obtained)

SIGNATURE SECTION

Patient Name: ______________________________________

Signature (Patient/Responsible Party): ____________________________________ Date: __________________

Name of Responsible party: ___________________________ Relationship to Patient: _______________________

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

Orthopaedic Surgery, Sports Medicine and Joint Replacement

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 or Left)

1. **Is your pain/concern due to: (Circle one of the below)**

   A. Gradual onset = skip to #'s 3& 4
   B. Accidental injury =complete #'s 2, 3, & 4

2. **Briefly describe the onset of your current symptoms:** ____

____

3. **Where did injury/accident occur:** **Work** **Home** **Auto** **Other:** __________________________

4. **Date symptoms started:** ___________________________

5. **Do you think your problem is related to work?** **YES** **or** **NO** (IF YES, ANSWER #5)

6. **Have you filed a workers' comp claim with your employer?** **YES** **or** **NO**
   If "yes"
   A. Have you notified our office? **YES** **or** **NO**
      a. If "NO", **immediately** call our office **at 434-5555.**
      b. If "YES", bring a copy of your claim form to your appointment.
   B. Has your claim been denied or put in delay? **YES** **or** **NO**
      a. If "YES", bring a copy of your denial/delay letter to your appointment.

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

Patient Name: ____

Signature (Patient/Responsible Party): ______________________________________ Date: ____________________

Name of Responsible Party: ____________________________ Relationship to Patient: ________________________

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

Orthopedic Surgery, Sports Medicine and Joint Replacement

MEDICAL HISTORY **Name:** ________________________

Previous Tests and Treatments

☐ Check here if none

☐ Physical Therapy	☐ Made it worse	☐ Made it better	☐ No effect
☐ Anti-inflammatories	☐ Made it worse	☐ Made it better	☐ No effect
☐ Narcotic medication	☐ Made it worse	☐ Made it better	☐ No effect
☐ Chiropractic/Manipulation	☐ Made it worse	☐ Made it better	☐ No effect
☐ Epidural steroid injection	☐ Made it worse	☐ Made it better	☐ No effect
☐ Steroid injection	☐ Made it worse	☐ Made it better	☐ No effect

☐ X-rays ☐ CT ☐ MRI

Please describe your current problem____

____

____

Current Medication(s):

☐ Check here if none Preferred Pharmacy: ___________________________

Name of Medication	Dose	Duration
______________________	______________	________________
______________________	______________	________________
______________________	______________	________________
______________________	______________	________________
______________________	______________	________________
______________________	______________	________________

Do you have any ALLERGIES?

☐ Yes ☐ No

1.______________________________________ Reaction: ________________________________

2.______________________________________ Reaction: ________________________________

3.______________________________________ Reaction: ________________________________

Social History (circle all that apply to you)

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

Employment? ☐ Work in the home ☐ Employed Full Time ~ Occupation ______________________

☐ Student ☐ Retired ☐ Employed Part Time ~ Occupation ______________________

Disabled? ☐ Permanent ☐ Temporary ~ Reason for Disability________________________________

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

History of substance abuse or IV drug use? ☐ No ☐ Yes What? ____________ How Long? _____

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

Children? ☐ No ☐ Yes #_____

Smoking? ☐ No ☐ Yes ____________ Packs per day for ____________ years.

Quit smoking? ☐ No ☐ Yes When? _______ Previously smoked ______ packs per day for ___ years

Chew tobacco? ☐ No ☐ Yes How much? ________________________

Family History

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

		Relationship			Relationship
Adopted, unknown family history	☐Yes ☐No	____________	Kidney disease	☐Yes ☐No	____________
Anemia	☐Yes ☐No	____________	Leukemia	☐Yes ☐No	____________
Arthritis	☐Yes ☐No	____________	Liver problems	☐Yes ☐No	____________
Asthma	☐Yes ☐No	____________	Lung problems	☐Yes ☐No	____________
Autoimmune disorder	☐Yes ☐No	____________	Neurological disease	☐Yes ☐No	____________
Back/Neck problems	☐Yes ☐No	____________	Osteoporosis	☐Yes ☐No	____________
Bleeding disorder	☐Yes ☐No	____________	Ovarian cancer	☐Yes ☐No	____________
Cancer type: _____________	☐Yes ☐No	____________	Psychiatric illness	☐Yes ☐No	____________
Cardiovascular	☐Yes ☐No	____________	Rheumatoid arthritis	☐Yes ☐No	____________
Deep Venous Thrombosis	☐Yes ☐No	____________	Scoliosis	☐Yes ☐No	____________
Depression	☐Yes ☐No	____________	Seizures	☐Yes ☐No	____________
Diabetes	☐Yes ☐No	____________	Sickle cell disease	☐Yes ☐No	____________
Heart problems	☐Yes ☐No	____________	Stomach problems	☐Yes ☐No	____________
Hemophilia	☐Yes ☐No	____________	Stroke	☐Yes ☐No	____________
Hepatitis type: ___________	☐Yes ☐No	____________	Thyroid disease	☐Yes ☐No	____________
Hypertension	☐Yes ☐No	____________	Tuberculosis	☐Yes ☐No	____________

Past Medical History (circle all that apply to you) ☐ CHECK HERE IF NONE APPLY

Dermatologic: lupus / melanoma / skin cancer

Immunologic: HIV/AIDS / tuberculosis

Neurological: epilepsy / seizure disorders / stroke

Renal / Urinary: hematuria / kidney problems / incontinence

Endocrine: diabetes / thyroid disorder

Head and Neck: Dentures / migraines / glaucoma

Genetic Background: Charcot-Marie-Tooth disease / congenital heart defect / hemophilia / sickle cell

Childhood Illnesses: chickenpox / polio / asthma

Female Reproductive: cancer / tumors

Male Reproductive: BPH / prostate conditions

Gastrointestinal: Crohn's disease / gastritis / GI bleed / irritable bowel syndrome / stomach or bowel problems / ulcer

Respiratory: asthma / bronchitis / emphysema / pulmonary embolism / shortness of breath / tuberculosis

Musculoskeletal: ankylosing spondylarthritis / arthritis conditions / carpal tunnel syndrome / fibromyalgia / osteoporosis / polio

Cardiovascular: aortic aneurysm / cardiac catheterization / cardiac disease / congestive heart failure / deep vein thrombosis / edema / heart valve conditions / myocardial infarction / stroke / hypertension

Hematologic/lymphatic: anemia / bleeding tendencies / hemophilia / hepatitis

Psychiatric: alcoholism / anxiety disorder / depression

Review of Systems (circle all that apply to you) ☐ CHECK HERE IF NONE APPLY

Allergic/ Immunologic: Seasonal Allergies

Cardiovascular: Chest pressure / cardiovascular problems or chest symptoms / Chest pain / Elevated blood pressure / Edema / Foot swelling / Heart attack / Heart palpations / Irregular heartbeat / Pacemaker

Constitutional Symptoms: Chills / Fever / Headache / Nausea / Dizziness / Fever, chills / night sweats / Sleep problems / Weight gain or loss / Weight loss, intentional / Weight loss, unintentional

Ears, Nose, Mouth, Throat: Difficulty with hearing / Cough / Difficulty with swallowing / Ear pain / Gum problems / Hoarseness / Sinus problems / Loss of hearing / Nose bleeds

Endocrine: Change in thirst or appetite / Dry hair / Dry skin / Unusual fatigue / Wt change / Thyroid disease

Eyes: Contact lenses / Eye or vision problems / Glasses / Loss of vision / Recent change in vision

Gastrointestinal: Blood in stool / Constipation / Diarrhea / Hemorrhoids / Nausea / Stomach problems / Vomiting /Ulcers

Genitourinary: Blood in urine / Difficulty empting / Inability to empty bladder / Painful urination / Urinating frequently at night / urine retention / Stress incontinence / Urinary incontinence / Difficulty in starting / Incontinence

Hematologic/ Lymphatic: Anemia / Ankle edema, swelling / Bleeding problems / Bruise easily / Recent night sweats / Sweats

Integumentary: Dry, Scaly skin / Itchiness, pruritis / Non healing wound / Rash

Musculoskeletal: Back pain / Decreased ROM / Difficulty getting out of a chair / Episodic weakness / Joint pain /Leg cramps / Leg pain / Neck pain / Weakness

Neurological: Black outs / Balance problems / Difficulty walking / Dizziness / Headaches / Migraines / Paralysis/ Seizures / Numbness / Trouble balancing / Paresis (muscle weakness) / Uncontrolled movements / Weakness / Stroke

Psychiatric: Anxious feeling / Binging and purging / Claustrophobia / depression / Generally satisfied with life / Paranoia / Psychiatric care / Nervous exhaustion / OCD

Respiratory: Asthma / Breathing difficulties / Chest pain with inspiration / Shortness of breath / Sleep apnea / Coughing up excess sputum

---

All Previous Surgeries ☐ CHECK HERE IF NO HISTORY OF PRIOR SURGERY

1.Date__________ Type_________________________ 4.Date__________ Type_____________________

2.Date__________ Type_________________________ 5.Date__________ Type_____________________

3.Date__________ Type_________________________ 6.Date__________ Type_____________________

Did you have any complications with your surgeries or anesthesia? ☐ No ☐ Yes
Explain if yes ____

Hip Evaluation
William F. Sima, M.D.

Name: ______________________________ **Date:** _____________

What hip are you here for? ☐ Right ☐ Left

Are you having: ☐ Snapping ☐ Popping ☐ Clicking

Your first symptoms began: ☐ Suddenly ☐ Gradually

As a result of: ☐ A fall ☐ Work injury ☐ Misstep ☐ Tripping ☐ MVA ☐ Sports injury

In detail please explain how you injured yourself ____________________________________
____
____

What date did this begin? _____________

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

I was evaluated by ________________________ at:

☐ Twin Cities Hospital ☐ French Hospital
☐ Sierra Vista Hospital ☐ Urgent Care ☐Other____________

Referring physician: ____________________________

- ☐ X-rays – Where: _________
- ☐ MRI – Where: __________
- ☐ Brace
- ☐ Physical Therapy - Where: _____________
- ☐ Cortisone Injection
- ☐ Surgery - With: _____________

Current Symptoms: ☐ Feeling great ☐ Much better ☐Somewhat better ☐ Same as it was ☐ Worse

Quality of Pain: ☐ No pain ☐ Achy ☐ Burning ☐ Dull ☐ Gnawing ☐ Pressure ☐ Sharp ☐ Stiffness ☐ Throbbing ☐ Tightness ☐ Tired feeling

Pain Radiates: ☐ Into the groin ☐ To the thigh ☐ Down the leg ☐ Down the leg to the foot

Pain Worse With: ☐ Bending ☐ Driving ☐ Exercise ☐ Getting in & out of chair ☐ Kneeling ☐ Pivoting ☐ Prolonged sitting ☐ Putting on socks & shoes ☐ Running ☐ Shopping ☐ Sitting ☐ Sitting Indian style ☐ Sleeping ☐ Squatting ☐ Stairs ☐ Standing ☐ Walking ☐ Weight bearing ☐ Other: ________

Other Symptoms: ☐ Intermittent locking ☐ Cracking ☐ Popping ☐ Catching ☐ Clicking ☐ Tightness

Walking Ability: ☐ Very limited ☐ Limited to a few stairs ☐ 1-5 blocks ☐ 5-10 blocks ☐ More than 10 blocks ☐ Not limited

Name: ______________________________ **Date:** __________

Sports Limitations:
- ☐ Has no limitations
- ☐ Participates with difficulty in: ______________________
- ☐ Unable to participate in: ______________________

Walking Aids:
- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Shopping cart
- ☐ Brace
- ☐ Shoe inserts
- ☐ Boots
- ☐ Brace for sports
- ☐ Orthotics

Medications for pain:
- ☐ Not required
- ☐ Used occasionally
- ☐ Required daily

Medications you have tried:
- ☐ Aleve
- ☐ AdvilVicodin
- ☐ Motrin/Ibuprofen
- ☐ Tylenol
- ☐ Celebrex
- ☐ Mobic
- ☐ Vioxx
- ☐ Darvocet
- ☐ Percocet
- ☐ Naprosyn
- ☐ Lodine
- ☐ Excedrin
- ☐ Gluc/Cond
- ☐ Arthrotec
- ☐ Vicodin
- ☐ Other: _________

Work Status:
- ☐ Full duty
- ☐ Light Duty
- ☐ Missed work since ____________
- ☐ Out of work
  - ☐ Since _____________
  - ☐ Since injury on _____________
  - ☐ Since surgery on ____________
- ☐ Unemployed
- ☐ Laid-off
- ☐ Retired
- ☐ Disabled
- ☐ Homemaker
- ☐ Student