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)

___ Hispanic or Latino

___ Not Hispanic or Latino

___ Unknown

___ Unreported/Refused

RACE: (PICK ONLY ONE)

___ American Indian or Alaska Native

___ Asian
- ___ Indian
- ___ Cambodian
- ___ Chinese
- ___ Japanese
- ___ Korean
- ___ Laotian
- ___ Vietnamese

___ Black or African American

___ Native Hawaiian/Other Pacific Islander
- ___ Filipino
- ___ Guamanian
- ___ Samoan

___ White

___ Other Race

___ Unknown

___ 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:** _____

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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

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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 _____

Shoulder / Clavicle Evaluation

William F. Sima, M.D.

Name: _____ **Date:**_____

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

Is you shoulder: □ Catching □ Stiff □ Instability □ Weak □ Painful

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

In detail please explain how your pain first started _____
_____
_____

What date did this begin? _____

<u>Previous Treatment</u>: □ I have not received any treatment for this condition

I was evaluated by _____ at:
□ Twin Cities Hospital □ Sierra Vista Hospital □ Family Doctor
□ French Hospital □ Urgent Care □ Other_____

Referring physician: _____

□ X-rays – Where: _____
□ MRI – Where: _____
□ Brace
□ Physical Therapy - Where: _____
□ Cortisone Injection
□ Surgery - With: _____

Severity of Pain: □ Doing great □ Same as it was □ Much better □ Worse □ Somewhat better

Quality of Pain: □ Pinching □ Dull □ Pulling □Stabbing □ Achy □ Gnawing □ Sharp □ Burning □ Itchy □ Throbbing

Does the Pain Radiate? □ Outside of upper arm □ To the thumb □ To the mid upper arm □ To the hand □ To the elbow □ To the neck □ To the wrist □ To the shoulder blade

Worse with: □ Reaching over head □ Sleeping □Throwing □ Reaching out to side □ Lifting □ Combing hair □ Reaching behind back □ Pushing □Dressing □ Reaching across chest □ Sports □ Driving

Weakness: □ With overhead lifting □ In shoulder □ With lifting

Name: _____ **Date:**_____

Paresthesias (tingling): □ Elbow □ Hand
□ Fingers (Thumb / Index / Long / Ring / Small) □ Shoulder
□ Forearm □ Whole Arm

Also experiencing: □ Grinding □ Popping
□ Clicking □ Cracking

Sports Limitations: □ Has no limitations
□ Participates with difficulty in: _____
□ Unable to participate in: _____

Instability: □ Shoulder □ Frequent instability □ Self reduced instability
□ Required ER care □ Dislocated □ Involuntarily dislocation

Stiffness: □ Yes □ No

Medications for pain: □ Not required
□ Used occasionally
□ Required daily

Medications you have tried:
□ Aleve □ Darvocet
□ Advil □ Percocet
□Motrin/ Ibuprofen □ Naprosyn
□Tylenol □ Lodine
□ Celebrex □ Exedrin
□ Mobic □ Vioxx
□ Glucos/Cond □ Vicodin

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