

William F. Sima, M.D., Inc.~Orthopaedic Surgeon

322 Posada Lane, Suite A ~ Templeton, Ca 93465

Phone: 805.434.5555 ~ Fax: 805.434.5502

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

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
- B. Accidental injury

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

3. **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: _____

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. Orthopaedic Surgeon
 322 Posada Lane, Ste A
 Templeton, CA 93465-4003
 (805)434-5555

PATIENT INFORMATION (REQUIRED)					
NAME (LAST, FIRST)					
MAILING ADDRESS			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		EMPLOYER/ SCHOOL		OCCUPATION	
ETHNICITY:	PREFERRED LANGUAGE:	PRIMARY MD		REFERRING MD	
FINANCIALLY RESPONSIBLE PARTY INFORMATION (REQUIRED IF DIFFERENT THAN ABOVE)					
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
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 appointment 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, M.D., Inc.

Orthopaedic Surgery, Sports Medicine and Joint Replacement

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I hereby authorize William Sima, M.D. to obtain any and all medical records pertinent to my care from any physician, hospital, or other health care professional.

I also hereby authorize William Sima, M.D. to release any medical records belonging to them concerning my care to any physician, hospital, or other health care professional. These may include but not be limited to mental health records protected by Lanterman Pertis Short Act, drug and alcohol abuse records and HIV test results to any except as specifically follows: _____

This authorization is effective now and will be in effect for the time that I am a patient of William Sima, M.D., or until I revoke it in writing.

William Sima, M.D. reserves the right to modify the privacy practices outlined in the notice.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

A copy of the HIPPA guidelines for the office of William Sima, M.D. was made available to me to read at the front desk. Upon request a copy can be made. I understand that due to these guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, test results and chart notes.

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible party: _____ Relationship to Patient: _____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the "Notice of Privacy Practices" on _____. The acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment.
- ☐ The patient declined to sign the acknowledgement.
- ☐ Other _____

Name of Staff Member: _____ Date: _____

Consent to Photograph/Videotape/Film/Interview Individuals

I give William Sima, M.D., Inc. permission to photograph, videotape, film and/or interview myself, and to publish said photographs, videotapes, films, written testimonials and/or interviews on the internet, Dr. Sima's web site and all other forms of media. The photographs, videotapes, etc. shall constitute the exclusive property of William Sima, M.D., Inc. and may be reproduced by William Sima, M.D., Inc., without compensation or payment to the individual concerned or any other person. I also hereby release William Sima, M.D., Inc. and his employees from all claims, demands, and liabilities whatsoever in connection with the above.

Patient Name: _____ Signature: _____ Date: _____

Responsible party: _____ Signature: _____ Relationship to Patient: _____

William F. Sima, M.D., Inc.
Orthopaedic Surgery, Sports Medicine and Joint Replacement

MEDICAL HISTORY

Name: _____

Previous Tests and Treatments

☐ Check here if none

- | | | | |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Made it worse | <input type="checkbox"/> Made it better | <input type="checkbox"/> No effect |
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Made it worse | <input type="checkbox"/> Made it better | <input type="checkbox"/> No effect |
| <input type="checkbox"/> Narcotic medication | <input type="checkbox"/> Made it worse | <input type="checkbox"/> Made it better | <input type="checkbox"/> No effect |
| <input type="checkbox"/> Chiropractic/Manipulation | <input type="checkbox"/> Made it worse | <input type="checkbox"/> Made it better | <input type="checkbox"/> No effect |
| <input type="checkbox"/> Epidural steroid injection | <input type="checkbox"/> Made it worse | <input type="checkbox"/> Made it better | <input type="checkbox"/> No effect |
| <input type="checkbox"/> Steroid injection | <input type="checkbox"/> Made it worse | <input type="checkbox"/> Made it better | <input type="checkbox"/> No effect |
| <input type="checkbox"/> X-rays <input type="checkbox"/> CT <input type="checkbox"/> 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 _____

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

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

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	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Liver problems	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Autoimmune disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Neurological disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Back/Neck problems	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Ovarian cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cancer type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Psychiatric illness	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Deep Venous Thrombosis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Sickle cell disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Stomach problems	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Hepatitis type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> 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 emptying / 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 _____

Elbow / Forearm Evaluation

William F. Sima, M.D.

Name: _____ Date: _____

Are you here for your: ☐ Elbow **Is it your:** ☐ Right **Are you:** ☐ Right handed
☐ Forearm ☐ Left ☐ Left handed

Your first symptoms began: ☐ Suddenly **As a result of:** ☐ A fall ☐ Work injury
☐ Gradually ☐ Misstep ☐ Tripping
☐ MVA ☐ Sports injury

In detail please explain how you injured yourself _____

What date did this happen? _____

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: _____

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

Where is your pain located? (Arm extended with palm up)
☐ Tip of elbow ☐ Inside of elbow
☐ Bend of elbow ☐ Other _____
☐ Outside of elbow

Quality of Pain: ☐ Aching ☐ Dull ☐ Sharp
☐ Burning ☐ Gnawing ☐ Other _____

Does your pain Radiate? ☐ Up the arm ☐ To the fingers (small, ring, long, index)
☐ To the forearm ☐ To the hand ☐ Other _____

Pain is worse with: ☐ Activity ☐ Pulling ☐ Sports
☐ Bending ☐ Pushing ☐ Throwing
☐ Heat ☐ Range of Motion ☐ Weather change
☐ Ice ☐ Rest ☐ Work
☐ Lifting ☐ Sleeping ☐ Other _____

Name: _____ Date: _____

Pain is relieved by:

<input type="checkbox"/> Heat	<input type="checkbox"/> Activity	<input type="checkbox"/> Sports
<input type="checkbox"/> Ice	<input type="checkbox"/> Work	<input type="checkbox"/> Tennis Support
<input type="checkbox"/> Rest	<input type="checkbox"/> Lifting	<input type="checkbox"/> Throwing

Weakness:

<input type="checkbox"/> Elbow bent	<input type="checkbox"/> Pulling	<input type="checkbox"/> Wrist extension
<input type="checkbox"/> Gripping	<input type="checkbox"/> Lifting	
<input type="checkbox"/> Elbow straight	<input type="checkbox"/> In the hand	

Associated Factors:

<input type="checkbox"/> Catching, unable to fully:	<input type="checkbox"/> Straighten elbow	<input type="checkbox"/> Bend elbow
<input type="checkbox"/> Intermittent catching	<input type="checkbox"/> Cracking	<input type="checkbox"/> Popping

Difficulty with:

<input type="checkbox"/> House & Yard work	<input type="checkbox"/> Driving	<input type="checkbox"/> Getting dressed
<input type="checkbox"/> Shopping	<input type="checkbox"/> Gripping	<input type="checkbox"/> Grasping
<input type="checkbox"/> Gardening	<input type="checkbox"/> Opening jars	<input type="checkbox"/> Writing

Medications for pain:

<input type="checkbox"/> Not required
<input type="checkbox"/> Used occasionally
<input type="checkbox"/> Required daily

Medications you have tried:

<input type="checkbox"/> Advil	<input type="checkbox"/> Motrin/Ibuprofen
<input type="checkbox"/> Vicodin	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Darvocet	<input type="checkbox"/> Celebrex
<input type="checkbox"/> Aleve	<input type="checkbox"/> Mobic
<input type="checkbox"/> Gluc/Cond	<input type="checkbox"/> Vioxx
<input type="checkbox"/> Arthrotec	<input type="checkbox"/> Percocet
<input type="checkbox"/> Naprosyn	<input type="checkbox"/> Lodine
<input type="checkbox"/> Excedrin	<input type="checkbox"/> Indocin

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