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

☐ 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 _____

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	☐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 _____

Hand / Wrist Evaluation
William F. Sima, M.D.

Name:_____ **Date:**_____

Are you here for your: ☐ Hand ☐ Wrist **Is it your:** ☐ Right ☐ Left **Are you:** ☐ Right handed ☐ Left handed

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

Nerve Conduction Study: ☐ Yes ☐ No Where? _____

Pain: (check all that apply)
☐ Aching ☐ Gnawing ☐ Tender
☐ Burning ☐ Sharp
☐ Dull ☐ Throbbing

Pain Radiates: ☐ To the shoulder ☐ To the forearm ☐ To the thumb
☐ To the index finger ☐ To the small finger ☐ Other:_____

Swelling: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Morning Stiffness: ☐ Intermittently, lasts ____ hours ☐ Everyday
☐ Everyday, lasts ____ hours ☐Other

Tingling: ☐ Postural ☐ Continual ☐ Nocturnal

Numbness: ☐ All fingers ☐ Thumb ☐ Small finger ☐ Entire arm
☐ All fingers except thumb ☐ Index finger ☐ Whole hand
☐ First three fingers ☐ Long finger ☐ Top of hand
☐ 4th and 5th fingers ☐ Ring finger ☐ Bottom of hand

Weakness: ☐ In the fingers ☐ In the wrist ☐ With lifting
☐ In the thumb ☐ With grasping

Name:_____ **Date:**_____

Difficulty with:
- ☐ House & yard work
- ☐ Getting in & out of chair
- ☐ Shopping
- ☐ Gardening
- ☐ Driving
- ☐ Gripping
- ☐ Sleep
- ☐ Opening jars
- ☐ Putting on a shirt
- ☐ Getting dressed
- ☐ Grasping
- ☐ Other: _____

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

Medications you have tried:
- ☐ Aleve
- ☐ Advil
- ☐ 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

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

Orthopaedic Surgery, Sports Medicine and Joint Replacement

WORKER'S COMPENSATION INJURY INFORMATION

HISTORY OF INJURY

Name _____ Date of the injury _____

What part of your body was injured? _____

Do you feel this injury is work related? ☐ Yes ☐ No If yes, why? _____

_____

Describe how the injury occurred _____

_____

How did you feel immediately after the injury and where did you have the pain? _____

_____

Did you report the injury to your supervisor? ☐ Yes ☐ No Supervisor's name_____

What happened after your injury? (e.g., you were taken to a hospital, you continued working, etc.)

_____

Who has treated you for this problem in the past?

_____ Dates:_____

_____ Dates:_____

_____ Dates:_____

Have you ever injured this body part in the past? ☐ Yes ☐ No
If yes, please explain _____

_____

Did your symptoms begin gradually? ☐ Yes ☐ No

Please describe how you feel now. Do you still have symptoms? If you still have symptoms, please indicate where it hurts, how often, how intense the pain is and if the pain travels:

_____

_____

Do you feel you have a disability resulting from this injury? ☐ Yes ☐ No
If yes, please explain _____

_____

Have you ever had any of the following:
☐ Motor vehicle accident ☐ Motorcycle accident ☐ Fall from any height
☐ Yes ☐ No If yes, please explain _____

_____

NAME_____

Have you ever had a permanent disability as a result of any injury or illness?
☐ Yes ☐ No If yes, when? _____

Please describe the disability _____

_____

WORK HISTORY

What company did you work for at the time of your injury? _____

What date did you begin employment with this company? _____

What position did you hold at the time of the injury? _____

_____

Please describe your normal job duties at time of injury (**including** lifting, bending, reaching, stooping with frequency and weight in pounds, if applicable. Include any protective devices)

_____

_____

Are you still working for this employer? ☐ Yes ☐ No

If **yes,** please answer the following:

Are you doing the same work? ☐ Yes ☐ No

If not, what are your job duties now?_____

_____

If **no**, please answer the following:

Last date worked: _____

Why did you leave?

☐ Lay-off ☐ Termination ☐ Resignation ☐ Other _____

After your injury, did you look for other jobs? ☐ Yes ☐ No

Work History:

Company Name	City	Job Duties	Dates Worked	Reason for Leaving

PREVIOUS WORK COMP RELATED INJURIES

Have you ever had previous work comp related injuries? ☐ Yes ☐ No If yes, please list below.

Body part injured Date of injury

_____

_____

Have you ever been considered disabled? ☐ Yes ☐ No If yes, please explain below.

_____

_____

_____ _____

M.D. Review Date