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

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

PATIENT INFORMATION

NAME (LAST, FIRST):		DOB:	SEX M F	HOME:
MAILING ADDRESS:		SSN:		WORK:
CITY/STATE/ZIP		MARITAL STATUS: S M D W		CELL:
PRIMARY CARE PROVIDER:	REFERRED BY:	LANGUAGE:		EMAIL:
OCCUPATION:	EMPLOYEMENT STATUS	ETHNICITY:		PREFERRED CONTACT:
EMPLOYER/SCHOOL		PHARMACY :		
EMERGENCY CONTACT NAME:		RELATIONSHIP:		PHONE:

GUARANTOR (Or person responsible for bill if different from above)

NAME (LAST, FIRST)		RELATIONSHIP TO PATIENT:		HOME:
MAILING ADDRESS:		DOB:	SEX M F	WORK:
CITY/STATE/ZIP:		SSN:		CELL:

PRIMARY INSURANCE

INSURANCE COMPANY:		
SUBSCRIBER NAME:	RELATIONSHIP TO PATIENT	
SSN	DATE OF BIRTH	SEX M F
MEMBER ID #	GROUP #	
INSURED'S EMPLOYER	OCCUPATION	

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY		
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	
SSN:	DATE OF BIRTH	SEX M F
MEMBER ID #	GROUP #	
INSURED'S EMPLOYER	OCCUPATION	

- 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.
- $50.00 non-sufficient funds (NSF) fee will be charged for all returned checks.
- $100.00 may be charged for appointment cancelled or missed without 24 hours' notice.
- $25.00 **minimum** charge may be charged for completion of forms.
- $25.00 may be charged for providing inaccurate, outdated, and/or incomplete insurance information that result in additional billing.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.
- There is a $500 surgical cancellation fee when you cancel your surgery less than 7 business days prior to your surgery.

Signature (Patient/Responsible Party) _____ Name and Relationship if not the patient _____ DATE _____

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

Orthopaedic Surgery, Sports Medicine and Joint Replacement

PATIENT NAME: _____ Date of Birth: _____

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: _____ Date of Birth: _____

NAME: _____ Relationship: _____ Date of Birth: _____

NAME: _____ Relationship: _____ Date of Birth: _____

_____	_____	_____
Signature (Patient/Responsible Party)	Name and Relationship if not the patient	DATE

An attempt was made to obtain an acknowledgement of receipt of the "Notice of Privacy Practices" but was not obtained because:

- □ *Patient was undergoing emergency treatment*
- □ *Patient declined to sign the acknowledgement*

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.

_____	_____	_____
Signature (Patient/Responsible Party)	Name and Relationship if not the patient	DATE

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

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.

Please complete this packet **PRIOR to your appointment** on: _____

TO AVOID RESCHEDULING: PLEASE arrive 15 minutes prior to your scheduled appointment and bring:

- ALL COMPLETED FORMS
- 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 ☐ LEFT

☐ Yes ☐ No Is injury due to an automobile accident, liability accident or Workman's Compensation?

If yes, please provide the following information:

Nature of accident: ☐ Auto ☐ Workers Compensation ☐ Liability

Date of accident: _____ Claim Number: _____

Claims address (Auto/Work Comp/Liability):

_____

MEDICARE COVERAGE

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

DO YOU HAVE MEDICARE COVERAGE? ☐ Yes ☐ No

If NO & and over 65, please explain why you do NOT have Medicare:

_____

If YES & under 65,

☐ Yes ☐ No Is your Medicare coverage due to disability?

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

If YES & Over 65,

☐ Yes ☐ No Are you covered by Employer Group Health Plan based on your own or spouse's current employer?
If yes, Medicare is secondary and primary information must be obtained

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

Signature (Patient/Responsible Party) _____ NAME (And Relationship if not the patient) _____ DATE _____

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

Orthopaedic Surgery, Sports Medicine and Joint Replacement

PATIENT NAME: _____ Date of Birth: _____

MEDICAL HISTORY

MEDICATION ALLERGIES

☐ CHECK HERE IF NO KNOWN MEDICATION ALLERGIES

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

CURRENT MEDICATIONS

☐ CHECK HERE IF NO CURRENT MEDICATIONS

Name of Medication	Dose	Duration

SOCIAL HISTORY

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

Employment? ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Work in the home
Occupation _____

Disabled? ☐ Permanent ☐ Temporary Reason for Disability _____

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

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

Smoking? ☐ No ☐ Yes ☐ Former: Quit _____ Smoked _____ packs per day for ___ years

FAMILY MEDICAL HISTORY

☐ CHECK HERE IF NONE APPLY

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

	Family Member		Family Member
☐ Anemia		☐ Hypertension	
☐ Asthma		☐ Kidney Disease	
☐ Autoimmune Disorder		☐ Liver Problems	
☐ Bleeding Disorder		☐ Lung Problems	
☐ Cancer: _____		☐ Osteoporosis	
☐ Cardiovascular		☐ Rheumatoid Arthritis	
☐ Deep Venous Thrombosis		☐ Seizures	
☐ Diabetes		☐ Stroke	
☐ Heart Problems		☐ Thyroid Disease	

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Orthopaedic Surgery, Sports Medicine and Joint Replacement

PAST MEDICAL HISTORY

☐ CHECK HERE IF NONE APPLY

- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Tendencies
- ☐ Cancer
- ☐ Cardiac Catheterization
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema Epilepsy/
- ☐ Seizure
- ☐ GI bleed
- ☐ Glaucoma
- ☐ Heart Valve Conditions
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Incontinence
- ☐ Irritable Bowel Syndrome
- ☐ Kidney problems
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Prostate Conditions
- ☐ Pulmonary Embolism
- ☐ Rheumatoid arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other: _____

REVIEW OF SYSTEMS

☐ CHECK HERE IF NONE APPLY

- ☐ Back Pain
- ☐ Bleeding Problems
- ☐ Blood in stool
- ☐ Blood in Urine
- ☐ Bruise Easily
- ☐ Chest Pain
- ☐ Chills
- ☐ Diarrhea
- ☐ Difficulty Walking
- ☐ Difficulty with Swallowing
- ☐ Elevated blood pressure
- ☐ Eye or Vision Problems
- ☐ Fever
- ☐ Heart Palpitations
- ☐ Incontinence
- ☐ Loss of hearing
- ☐ Loss of vision
- ☐ Nausea
- ☐ Non Healing Wound
- ☐ Rash
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Weight Change

SURGICAL HISTORY

☐ CHECK HERE IF NO PRIOR SURGERIES

	SURGERY	DATE	SIDE		SURGERY	DATE	SIDE
1.				4.			
2.				5.			
3.				6.			

Did you have any complications with surgeries or anesthesia? ☐ YES ☐ NO

If YES, Explain: _____

What Health Care providers have you seen in the past 2 years? _____

_____

Shoulder Evaluation
William F. Sima, M.D.

Name:_____ **Date:** _____

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

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

What date did your pain first begin? _____

In detail please explain how you injured yourself

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

I was evaluated by _____

☐X-rays at: _____ ☐Physical Therapy ☐Cortisone Injection ☐Brace

☐MRI at: _____ ☐Surgery by Dr: _____

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

Quality of Pain:
- ☐No pain
- ☐Achy
- ☐Burning
- ☐Dull
- ☐Gnawing
- ☐Itchy
- ☐Pinching
- ☐Pulling
- ☐Sharp
- ☐Throbbing

Pain Radiates to:
- ☐ Outside of upper arm
- ☐ To the mid upper arm
- ☐ To the elbow
- ☐ To the wrist
- ☐ To the thumb
- ☐ To the hand
- ☐ To the neck
- ☐ To the shoulder blade

Pain is worse with:
- ☐Reaching over head
- ☐Reaching out to the side
- ☐Reaching behind back
- ☐Reaching across chest
- ☐Sleeping
- ☐Lifting
- ☐Pushing
- ☐Sports
- ☐Throwing
- ☐Combing Hair
- ☐Dressing
- ☐Driving

Weakness:
- ☐With overhead lifting
- ☐With lifting
- ☐In the shoulder

Paresthesias (Tingling):
- ☐Elbow
- ☐Fingers
- ☐Forearm
- ☐Hand
- ☐Shoulder
- ☐Whole Arm

Also Experiencing:
- ☐Grinding
- ☐Clicking
- ☐Popping
- ☐Cracking

Instability:
- ☐Shoulder
- ☐Frequent Instability
- ☐Self Reduced instability
- ☐Required ER care
- ☐Dislocated

Stiffness:
☐Yes ☐No

Work Status:
- ☐Full duty
- ☐Light Duty
- ☐Missed work since _____
- ☐Out of work
- ☐Unemployed
- ☐Retired
- ☐Disabled
- ☐Student

PAIN:

What amount of shoulder pain have you experienced in the last week doing the following:

1. **Reaching overhead:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
2. **Reaching behind back:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
3. **Lifting:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

FUNCTION (daily living):

4. **Showering and personal hygiene:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
5. **Putting on shirt:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
6. **Getting in and out of chair:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme