OSA
ORTHOPEDIC SPECIALTY
ASSOCIATES

Mark G. Kowall, M.D., M.B.A. Mark F. Mooney, M.D.

Thank you for choosing our office to provide your orthopedic care. We are dedicated to providing you and your family with the finest medical care possible.

Patient Registration

Name:_____ Date: _____ Age:_____

Address: _____

Home Phone:_____ Cell Phone: _____

Social Security #:_____ Drivers License #: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____

Preferred Pharmacy (Name/Location): _____

Date of Birth: _____ Gender: _____

Height: _____ Weight: _____ R or L Hand Dominant

Would you like to have access to our online Patient Portal where you may request an appointment, view prescriptions, view your account, make a payment, and find patient education materials? No ____ Yes ____

If Yes, provide your email address (Portal link is often marked as spam): _____

Social History

Marital Status: _____ Number of Children: _____

Occupation: _____ Retired

Preferred Language: English Other: _____

Ethnicity: Not Hispanic/Latino, Hispanic/Latino, Unknown

Exercise (daily/weekly/never):_____ Exercise Type: _____

Aspirin (yes/no): _____ How much: _____

Tobacco (yes/no/quit) _____ packs per day for _____ years

Alcohol (yes/no/quit): Daily 1-2x/week 1-2x/month Other: _____

78 S. Main Street, Templeton, CA 93465 Phone (805) 434-0999 Fax (805) 434-5267

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Chief Complaint

Doctor requesting Orthopedic Consult (**Which doctor sent you here?**): _____

Why are you seeing the doctor today? _____

Date of injury? _____

How did injury occur? _____

Treatment for this injury? _____

_____

Medications taken for this condition? _____

What makes the pain better? _____

What makes the pain worse? _____

Have you had any x-rays or an MRI (when/where)? _____

Medical History

Current Medications & Dose: _____

_____

_____

_____

Medication Allergies: _____

Medical Problems (diabetes, arthritis, stroke, high blood pressure, heart attack, None):

Other: _____

_____

_____

Previous Surgeries and Dates: _____

_____

_____

_____

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Family History

	Alive	Deceased	Age	Health status or cause of death
Father:				
Mother:				
Brother/Sister:				
Brother/Sister:				

Review of Systems:

Are you currently having or have you had problems with: (Please explain)

Eyes: No ___ Yes___ : _____

Ear/Nose/Mouth/Throat: No ___ Yes___ : _____

Neck/Back: No___ Yes___ : _____

Respiratory: No___ Yes___ : _____

Cardiovascular: No___ Yes___ : _____

Gastrointestinal: No___ Yes___ : _____

Genitourinary: No___ Yes___ : _____

Liver/Hepatitis: No___ Yes___ : _____

High Blood Pressure: No___ Yes___ : _____

TB/AIDS/HIV: No___ Yes___ : _____

Endocrine/Thyroid: No___ Yes___ : _____

Psychological: No___ Yes___ : _____

Numbness: No___ Yes___ : _____

Arthritis: No___ Yes___ : _____

Cancer: No___ Yes___ : _____

Skin: No___ Yes___ : _____

Reviewed by:_____ **M.D** **Date:**_____

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Insurance Information

If you are covered by insurance, please present your card to the receptionist and make necessary copayment prior to seeing the doctor.

Is this a worker's compensation injury? Yes____ No____

Insured's Name: _____

Relationship to Patient: _____

Address: _____

Name of Insurance: _____

Policy #: _____ Group #: _____

- I assign all my medical/surgical benefits to Orthopedic Specialty Associates and I understand that I am financially responsible for all charges I incur.
- I hereby authorize Orthopedic Specialty Associates to release all necessary information to secure payment of benefits. Given the complex nature of medical insurance we ask our patients to help us assure proper billing and authorizations.
- I hereby authorize Orthopedic Specialty Associates to release information to any provider that I am referred to, as well as request past medical information from any provider that has treated me.

Signed: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of the medical practice's Notice of Privacy Practices. A copy is available at any time at my request.

Signed: _____ Date: _____

Print Name: _____ Phone: _____

Patient Name (if different than above): _____

If not signed by the patient, please indicate:

___ Parent of Guardian of Minor Patient

___ Guardian or Conservator of an Incompetent Patient

___ Beneficiary or Personal Representative of Deceased Patient