Optimotion ORTHOPAEDICS
Recover Faster.
STEVE V. NGUYEN, MD
JEAN FAIRCHILD, PA / AMANDA ROGAN, PA
5979 VINELAND RD. SUITE 101. ORLANDO, FL 32819
PHONE: 407-355-3120 / FAX: 407-355-3119

Dear Sir/Madame

In order for our office to prepare for your visit, please fill out every page of this packet.

- Fax the packet to our office at 407-355- 3119 ONE WEEK PRIOR TO APPOINTMENT

OR

- Mail packet to 5979 Vineland Rd. Suite 101 Orlando Florida 32819 10 DAYS PRIOR TO APPOINTMENT

Our office will send you email/text messages regarding your appointment date and time.

Optimotion Orthopaedic staff

Optimotion Orthopaedics
Dr. Steve V Nguyen, M.D.
5979 Vineland Rd. Suite 101 Orlando, FL 32819
Phone: (407) 355-3120 / Fax: (407) 355-3119

Appointment Date: _____ **Appointment Time:** _____

PATIENT REGISTRATION FORM
PREFERRED METHOD OF COMMUNICATION

Referred by: ☐ Friend ☐ Family ☐ Physician: _____ ☐ Other: _____

PATIENT INFORMATION

First Name: _____ Middle: _____ Last Name: _____
Address: _____ SSN: _____
_____ Date of Birth: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Gender: _____ Race: _____
Ethnicity: _____ First Language: _____ Marital Status: _____
Occupation: _____ Employer: _____ Phone: _____
Employer Address Line: _____ Employer City, State, Zip: _____
Primary Care Physician: _____ PCP Phone: _____

EMERGENCY CONTACT/SPOUSE/GUARDIAN/SIGNIFIANT OTHER

First Name: _____ Middle: _____ Last Name: _____
Address: _____
_____
City, State, Zip: _____
Home Phone: _____ Cell phone: _____ Work Phone: _____
Employer: _____ Employer Phone: _____ _____
Employer Address Line: _____ Employer City State, Zip: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance: _____ Policy Number: _____
Policy Holder's Name: _____
Mailing Address Line: _____ City, State, Zip: _____
Holder's DOB: _____ Holder's Phone: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance: _____ Policy Number: _____
Policy Holder's Name: _____
Mailing Address Line: _____ City, State, Zip: _____
Holder's DOB: _____ Holder's Phone: _____ Group Number: _____

FINANCIAL RESPONSIBILITY

Person Financially Responsible for Balance Not Covered by Insurance: ☐ Patient ☐ Spouse ☐ Parent ☐ Guardian
Name: _____
Phone: _____
Address: _____
_____

Optimotion Orthopaedics
Dr. Steve V. Nguyen, M.D.

First Name: _____
Last Name: _____
Date of Birth: _____

CONSENT TO EXAMINATION AND TREATMENT
INSURANCE ASSIGNMENT AND RECORDS AUTHORIZATION

I hereby consent to examination and treatment as deemed necessary by and its physicians. I Hereby authorize **Steven V Nguyen M.D.,** and assisting physicians to furnish patient health information concerning my relevant medical history (including but not limited to the super confidential information listed above) to any of the following: Other healthcare providers involved in my care, insurance carriers, attorneys and adjustors. I hereby assign to Steven V Nguyen, M.D., and assisting physicians all payments for Medical Services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ ☐ Patient ☐ Parent/Guardian Date/Time: _____

PATIENT RELEASE

I, _____, hereby authorize Optimotion Orthopaedics and its physicians to release any or all of my patient health information including super confidential information to the person(s) listed below. (Example: A Spouse or relative may be involved in billing and insurance inquires or medication refills.)

Signature: _____ Date/Time: _____

Name:	Relationship to Patient	Phone:

PRIVACY NOTICE

Inspect and Copy Your Protected Health Information (PHI): You have the right to inspect and copy your protected health information that may be used to make decisions about your care, with the exception of psychotherapy notes. If you want to see or copy your medical information, you must submit your request in writing to the Privacy Site Coordinator or to the Optimotion Orthopaedics Privacy Officer. If you request copies of information, the cost will be $1.00 per page for the first 25 pages then .25 per page after.

In accordance with Health Information Portability and Accountability Act (HIPPA), patients of Optimotion Orthopaedics are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. Optimotion Orthopaedics will strive to ensure that patient information is used only for purposes authorized by the patient and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies. Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice.

CANCELLATION POLICY

<u>If unable to keep your appointment, kindly give 24-hour notice to avoid $25.00 no-show charge.</u>

Copays, deductibles, and coinsurance will be collected prior to treatment. If payment is not received at the time services are rendered the patient will receive 3 statements in regards to an outstanding balance. If your account is still delinquent, your account will be sent to collections.

Signature: _____ Date/Time: _____

Optimotion Orthopaedics
5979 Vineland Rd. Suite 101 Orlando, FL 32819
Phone: (407) 355-3120 Fax: (407) 355-3119

Name: _____ Date of Injury or onset of pain: _____

Which part(s) of body do you want to discuss treatment for?

☐ Knee ☐ Hip ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Ankle ☐ Other _____

Which side of the body? Place R for Right or L for Left or B for Both for each complaint above.

What is your pain level on a scale of 0 to 10? 0 (no pain) – 10 (worst) _____

Which prior treatments have you tired? Please check all that apply:

☐ Anti-inflammatory medications such as Aspirin, Ibuprofen, Naproxen, Indomethacin, Meloxicam, Celecoxib, Diclofenac, or Other _____ **Duration?** _____

☐ Physical Therapy When:_____

☐ Activity Modification (Reduced physical activities such as sports, exercise, stairs or walking)

☐ Assistive devices: ☐ Bracing ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Other_____

☐ Weight loss Did this help? Cicle: Yes No

☐ Injections: ☐ Cortisone ☐ Hyalgan ☐ Synvisc when _____ how many time_____

Other_____

☐ Arthroscopic (scope) surgery? By who _____When _____

☐ Other:_____

Have you ever consulted with any other physician regarding your problem?

☐ Yes ☐ No, if yes: Physician's name_____ Phone:_____

What was the determination and recommended treatment given by this physician? _____

_____

Have you ever undergone joint replacement? ☐ Yes ☐ No, if yes by who?_____

When: _____ What part of the body? _____ Left or Right

Name of component/prosthesis if known? _____

Patient's Name _____ Signature _____ Date _____

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Surgery Deposit Consent

Dear Sir/Madam,

Please make a refundable surgery deposit of $200.00 at the front desk to facilitate scheduling of your surgery. **PAYMENT IS ONLY ACCEPTED BY DEBIT/CREDIT CARD.** This requirement is waived if you are an established patient scheduling 2nd surgery with us.

After making the surgery deposit, you will receive the following:

1. **PowerPoint presentation:** Please pay attention as it contains important information regarding your surgery. Following this, our surgery coordinator will assist you in scheduling your surgery date and address all concerns.
2. **Surgery packet:** *It is extremely important that you read the entire packet and save it for reference.* Please follow all the pre- and post-operative instructions mentioned in the surgery packet strictly.

If you want your surgery to be moved to an earlier date, please inform our surgical coordinator to place you on the surgery cancellation list. We will contact you if there is an available slot.

Surgery cancellation/postponing policy:

- If you want to cancel/postpone your surgery, our office *needs to receive the notice more than 30 days* prior to your scheduled surgery date by certified mail or fax. Your surgery deposit will be fully refunded in this case.
- Your surgery deposit **will not** be refunded if you cancel/postpone your surgery **within 30 days** of the surgery date for a **non-medical reason.**

Dr. Steve B. Nguyen

Patient Signature: _____ Date: _____

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FALL RISK ASSESSMENT

Patient Name:_____ DOB : _____

1. Do you use an assisted device? (walker, cane or crutches) ☐ YES ☐ NO
2. Have you fallen within the past year? ☐ YES ☐ NO
3. Do you feel a buckling sensation? ☐ YES ☐ NO
4. Are you wheelchair or home bound? ☐ YES ☐ NO

Patient Signature: _____ Date: _____

Current Medication List

Patient Name: _____ **DOB:** _____
List Allergies: _____
_____
Height: _____ **Weight:** _____

Are you currently taking any nicotine product? **Yes** ☐ **No** ☐

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: prescription and over the counter medications, herbals, vitamin/mineral/dietary supplement

Name of Current Medication/Dose (example: Aspirin tablet 325 mg)	**Frequency/Route of Administration** (example: 3 times daily orally)	**Start Date**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

Patient Name: **Date:**

Medical disorders: If you have had any of the following, Place Mark inside Circles

- ☐ No Medical History
- ☐ AIDS/HIV
- ☐ **Alcoholism**
- ☐ **Alzheimer's**
- ☐ **Anemia**
- ☐ **Rheumatoid Arthritis**
- ☐ **Asthma**
- ☐ **Blood Clot Leg**
- ☐ **Blood Clot Lung**
- ☐ **Other Disease** (list below)
- ☐ Stroke
- ☐ Cancer Breast
- ☐ Cancer **Colon**
- ☐ Cancer **Lung**
- ☐ Cancer **Prostate**
- ☐ **COPD**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Drug Abuse**
- ☐ **Blood thinners (Coumadin, Plavix, aspirin, etc)**
- ☐ Sleep Apnea
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Seizures
- ☐ Ulcers, Bleeding

Surgical History: If you have had any of the following, Place Mark inside Circles

- ☐ No Surgical History Reported
- ☐ Carpal Tunnel Left Wrist
- ☐ Arthroscopy Left Elbow
- ☐ Arthroscopy Left Shoulder
- ☐ Arthroscopy Left Ankle
- ☐ Arthroscopy Left Knee
- ☐ Arthroscopy Left Hip
- ☐ Left Hip Replacement
- ☐ Left Knee Replacement
- ☐ Spinal Fusion
- ☐ Other Surgery (list in the box below)
- ☐ Cardiac (Heart)
- ☐ Carpal Tunnel Right Wrist
- ☐ Arthroscopy Right Elbow
- ☐ Arthroscopy Right Shoulder
- ☐ Arthroscopy Right Ankle
- ☐ Arthroscopy Right Knee
- ☐ Arthroscopy Right Hip
- ☐ Right Hip Replacement
- ☐ Right Knee Replacement
- ☐ Laminectomy
- ☐ Fracture Surgery

Patient Name: **Date:**

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- ☐ **AIDS/HIV**
- ☐ **Anemia**
- ☐ **Blood Clots**
- ☐ **Cancer**
- ☐ **Coronary Artery Disease**
- ☐ **Diabetes**
- ☐ **Gout**
- ☐ **Heart Attack**
- ☐ Hemophilia
- ☐ **Hypertension**
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Muscle Disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

Mother Medical History

- ☐ **AIDS/HIV**
- ☐ **Anemia**
- ☐ **Blood Clots**
- ☐ **Cancer**
- ☐ **Coronary Artery Disease**
- ☐ **Diabetes**
- ☐ **Gout**
- ☐ **Heart Attack**
- ☐ Hemophilia
- ☐ **Hypertension**
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Muscle Disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

Sibling Medical History

- ☐ **AIDS/HIV**
- ☐ **Anemia**
- ☐ **Blood Clots**
- ☐ **Cancer**
- ☐ **Coronary Artery Disease**
- ☐ **Diabetes**
- ☐ **Gout**
- ☐ **Heart Attack**
- ☐ Hemophilia
- ☐ **Hypertension**
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Muscle Disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

Patient Name: **Date:**

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- ☐ Weight Loss/Gain
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever

Cardiovascular
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Rheumatic Fever
- ☐ Palpitations
- ☐ Has Pacemaker

Musculoskeletal
- ☐ Joint Pain
- ☐ Arthritis
- ☐ Muscular Weakness
- ☐ Stiffness
- ☐ Muscular Pain

Eyes
- ☐ Glasses or Contacts
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Excessive Tearing

Skin
- ☐ Rashes
- ☐ Sores
- ☐ Lumps
- ☐ Dryness
- ☐ Itching

Blood or Lymph
- ☐ Anemia
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Swollen Glands

Ear Nose Mouth Throat:
- ☐ Ears Ringing
- ☐ Earaches
- ☐ Hearing Aid
- ☐ Frequent Colds
- ☐ Nasal Discharge
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Dentures
- ☐ Bleeding Gums
- ☐ Frequent Sore throats

Neurological
- ☐ Headache
- ☐ Dizziness
- ☐ Seizures
- ☐ Loss of Sensation
- ☐ Vertigo

Gastrointestinal
- ☐ Heart Burn
- ☐ Rectal Bleeding
- ☐ Abdominal Pain
- ☐ Gallbladder trouble
- ☐ Hepatitis

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis

Genitourinary
- ☐ Blood in Urine
- ☐ Urinary Infections
- ☐ Kidney Stones
- ☐ Burning Urination
- ☐ Sexual Disease

Endocrine
- ☐ Thyroid Trouble
- ☐ Excessive Sweating
- ☐ Excessive thirst

Immunologic
- ☐ Reactions to Drugs
- ☐ Skin Rashes
- ☐ Reactions to Foods

Psychological
- ☐ Nervousness
- ☐ Depression
- ☐ Mood Changes

Patient Name: **Date:**

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	◯ Yes	◯ No	◯ Former
Use Alcohol?	◯ Yes	◯ No	
Use Caffeine?	◯ Yes	◯ No	
Use Illicit Drugs?	◯ Yes	◯ No	

I do not use any of the above ☐

Hand Dominance? ◯ Right Handed ◯ Left Handed

Females Only:

Could you be pregnant? ◯ Yes ◯ No

Allergies: Do you have allergies to any of the following medications or substances

☐ No Known Allergies	☐ Aspirin	
☐ Penicillin	☐ Amoxil	☐ Tegretol
☐ Codeines	☐ Keflex	☐ Bactrim
☐ Sulpha Drugs	☐ Cefzil	☐ Pediazole
☐ Iodine / Shellfish	☐ Ceftin	☐ Dilantin
☐ Ampicillin	☐ Suprax	☐ Novacaine
☐ Vantin	☐ Septra	☐ Insulin
☐ Depakene	☐ Lamictal	☐ Lidocaine

Other Allergies:

☐ Latex ☐ IVP/X-Ray Dye ☐ Metal ☐ Egg/Avian (Bird)

List any other allergies in this box