

DATE OF APPT _____

You MUST bring X-RAY / MRI FILMS to this appt (if any were taken) Also bring a photo I.D., Ins Card and a list of all your medications. Thank you.

REGISTRATION FORM

Valley Ridge Orthopedic Center

Brock S. Cummings, M.D.

Loren Ott, PA-C

6283 Clark Road, Suite 15, Paradise, CA 95969

530-876-0410

Last Name _____	First Name _____	Middle _____
Mailing Address _____	City/State _____	Zip _____
Phone _____	Cell Phone _____	Age _____ Sex _____ Date of Birth _____
SS # _____	Drivers Lic. # _____	Married ___ Single ___ Widowed ___ Divorced ___ Separated ___
Occupation _____	Employer _____	Phone _____
Full-time _____	Part-time _____	Disabled _____ Retired _____ Student _____

Spouse _____	Phone _____
Nearest Relative/Friend _____	Phone _____
How did you hear about us?	
1. Physician Referred: _____	2. Friend ___ 3. Radio/TV ___ 4. Internet ___ 5. Phone Book ___
Family Physician _____	Phone _____
Pharmacy _____	

IS THIS AN INJURY? Yes ___ No ___ Date of Injury: _____ Type: W/Comp ___ Auto ___ Other _____

IF PATIENT IS MINOR, RESPONSIBLE PARTY INFORMATION:		
NAME _____	D.O.B. _____	SOC SEC # _____

We will bill your insurance: please present insurance cards & co-pay at time of each visit.

Primary Insurance: _____ Policy Number _____

Secondary Insurance: _____ Policy Number _____

I authorize any holder of medical information about me to release it to any insurance company, agency or legal party entitled to information regarding my illness, accident or treatment. I assign all Medical and/or Surgical benefits to Brock Cummings, M.D. For any services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance company.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature of Patient or Responsible Party

Date

Patient Name

If not signed by the patient, please indicate relationship:

- _____ Parent or Guardian of minor child
- _____ Guardian or Conservator of the patient
- _____ Beneficiary or Personal Representative of deceased patient

NEW PATIENT QUESTIONNAIRE

Please fill in each blank

WHAT ARE WE SEEING YOU FOR TODAY: _____

WHEN DID THE PROBLEM START: _____

HOW DID THE PROBLEM START: _____

DESCRIBE THE SYMPTOMS: (sharp pain, dull ache, numbness, tingling, etc)

DESCRIBE THE SEVERITY: (mild, moderate, severe, disabling, etc)

DURATION OF SYMPTOMS: (hours, days, months, years, intermittent, etc)

TIMING OF SYMPTOMS: (with activity, at night, while typing, etc)

WHAT MAKES THE PROBLEM BETTER: (rest, heat, ice, medications, etc)

WHAT MAKES THE PROBLEM WORSE: (activity, reaching overhead, lifting, etc)

PREVIOUS TREATMENT FOR THIS PROBLEM:

Injections _____ Physical Therapy _____ Medication _____ Surgery _____

ANY AND ALL MEDICATIONS: Or bring a list of your meds, including the dosage:

ALCOHOL: Rare _____ Occasional _____ Moderate _____ Heavy _____ None _____

“STREET DRUGS”: What Kind _____ How Often _____ None _____

SMOKING: Packs/day _____ Previous Smoker? _____ None _____

DISEASES IN YOUR FAMILY: _____

Doctor's Notes:

CONDITIONS: Check those you have or have had in the past.

<ul style="list-style-type: none"><input type="checkbox"/> Anemia<input type="checkbox"/> Anxiety<input type="checkbox"/> Anti-Coagulation Therapy<input type="checkbox"/> Arthritis<input type="checkbox"/> Asthma<input type="checkbox"/> Bleeding Disorder<input type="checkbox"/> Bronchitis<input type="checkbox"/> Cancer<input type="checkbox"/> Cataracts<input type="checkbox"/> Chemical Dependency<input type="checkbox"/> Chemotherapy<input type="checkbox"/> COPD<input type="checkbox"/> Coronary Artery Disease<input type="checkbox"/> Diabetes<input type="checkbox"/> Depression<input type="checkbox"/> Emphysema<input type="checkbox"/> Epilepsy / Seizures<input type="checkbox"/> Glaucoma<input type="checkbox"/> GERD<input type="checkbox"/> Heart-Irregular beat/Atrial Fibrillation/Murmur<input type="checkbox"/> Hepatitis<input type="checkbox"/> High Cholesterol<input type="checkbox"/> High Blood Pressure<input type="checkbox"/> HIV/AIDS	<ul style="list-style-type: none"><input type="checkbox"/> Kidney Disease<input type="checkbox"/> Liver Disease<input type="checkbox"/> Mental Illness<input type="checkbox"/> Migraine Headaches<input type="checkbox"/> MRSA<input type="checkbox"/> Multiple Sclerosis<input type="checkbox"/> Oxygen Dependant<input type="checkbox"/> Osteoarthritis<input type="checkbox"/> Osteopenia<input type="checkbox"/> Pacemaker<input type="checkbox"/> Pneumonia<input type="checkbox"/> Polio<input type="checkbox"/> Prostate Problems<input type="checkbox"/> Pulmonary Embolus<input type="checkbox"/> Restless Leg Syndrome<input type="checkbox"/> Rheumatoid Arthritis<input type="checkbox"/> Sleep Apnea/C-Pap Machine<input type="checkbox"/> Stroke<input type="checkbox"/> Transfusion History<input type="checkbox"/> Thyroid Problems<input type="checkbox"/> Tuberculosis<input type="checkbox"/> Ulcers<input type="checkbox"/> Urinary Problems<input type="checkbox"/> Valvular Heart Disease
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<p>Check those you have had in the last 3 months</p> <p>General:</p> <ul style="list-style-type: none"><input type="checkbox"/> Weight Loss<input type="checkbox"/> Weight Gain<input type="checkbox"/> Frequent Fevers<input type="checkbox"/> Fatigue <p>Head and Neck:</p> <ul style="list-style-type: none"><input type="checkbox"/> Frequent Headaches<input type="checkbox"/> Visual Changes<input type="checkbox"/> Difficulty with smell or taste<input type="checkbox"/> Difficulty swallowing <p>Cardiovascular:</p> <ul style="list-style-type: none"><input type="checkbox"/> Chest Pains<input type="checkbox"/> Racing Heart beat<input type="checkbox"/> Difficulty breathing when lying down<input type="checkbox"/> Swelling in your legs<input type="checkbox"/> Dizzy spells or light-headedness spells <p>Respiratory:</p> <ul style="list-style-type: none"><input type="checkbox"/> Shortness of breath<input type="checkbox"/> Cough<input type="checkbox"/> Wheezing<input type="checkbox"/> Coughing up blood <p>Gastrointestinal:</p> <ul style="list-style-type: none"><input type="checkbox"/> Abdominal pain<input type="checkbox"/> Indigestion / Heartburn<input type="checkbox"/> Diarrhea<input type="checkbox"/> Constipation<input type="checkbox"/> Blood in Stool	<p>Genitourinary:</p> <ul style="list-style-type: none"><input type="checkbox"/> Pain with Urination<input type="checkbox"/> Incontinence<input type="checkbox"/> Discharge<input type="checkbox"/> Blood in Urine <p>Neurologic:</p> <ul style="list-style-type: none"><input type="checkbox"/> New onset of weakness<input type="checkbox"/> Numbness or tingling<input type="checkbox"/> Loss of Balance<input type="checkbox"/> Coordination Problems <p>Musculoskeletal:</p> <ul style="list-style-type: none"><input type="checkbox"/> Joint Pain<input type="checkbox"/> Joint Swelling<input type="checkbox"/> Joint Stiffness<input type="checkbox"/> Joint Instability <p>Psychosocial:</p> <ul style="list-style-type: none"><input type="checkbox"/> Depression<input type="checkbox"/> Anxiety<input type="checkbox"/> Drug or Alcohol Problem<input type="checkbox"/> Recent Stressors or change in lifestyle <p>Hematologic / Lymphatic:</p> <ul style="list-style-type: none"><input type="checkbox"/> Anemia<input type="checkbox"/> Easy Bruising<input type="checkbox"/> Difficulty with stopping bleeding<input type="checkbox"/> Swollen or tender glands
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ALLERGIES TO MEDICATIONS: _____

Latex or Iodine? _____

PREVIOUS SURGERIES: _____

Effective: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Brock Cummings, M.D. 6283 Clark Rd, #15, Paradise, CA 95969 530-876-0410
is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

We will use your health information for treatment: For example: Information obtained by your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations. Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Specialized government functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Coroners/Funeral Directors: We may disclose health information to funeral directors/coroners consistent with applicable law to carry out their duties.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing and controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Your Health Information Rights: Although your record is the physical property of Brock Cummings, M.D., this information belongs to you. You have the rights to:

Obtain a paper copy of this notice of information practices upon request, Inspect and copy your health record as provided for in 45 CFR 164.524, Amend your health record as provided in 45 CFR 164.528, Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528, Request communications of your health information by alternative means or at alternative locations, Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, It is a requirement that the above requests be in writing. We are not required to agree with your requests. It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

Should our information practices change, we will notify you on your next visit.

We will not use or disclose your health information without your written authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received written revocation of the authorization according to the procedures included in the authorization.

Complaints: Complaints about this notice or how this medical practice handles your health information should be directed to the Privacy Officer listed above. If you are not satisfied with the manner in which this office handles complaints, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights - Hubert H. Humphrey Bldg., 200 Independence Ave., S.W. Room 509f HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.