William C. Eves, M.D., Inc.

Diplomate, American Board of Orthopaedic Surgery
Fellowship Trained in Sports Medicine and Arthroscopy

PATIENT INFORMATION

Name: *(Nombre)* _____ _____ _____
First *(Nombre)* Middle *(Segundo Nombre)* Last *(Appellido)*

Date of Birth: *(Fecha de Nacimiento)* ___/___/_____ **Gender**: *(género)* Male ( ) *(masculine)* Female ( ) *(femenino)*

Social Security Number: *(Numero de Seguro Social)* _____ - _____ - _____

Drivers License Number: *(Numero de Licincia de Conducir)* _____ **State:** *(Estado)* _____

Address: *(Domicilio)* _____ **City**: *(Ciudad)* _____

State: *(Estado)* _____ **Zip**: *(Zona Postal)* _____ ( ) **Married**: *(Casado/a)* ( ) **Single**: *(Soltero/a)* ( )**Other**: *(otro)*

Telephone: *(Telefono)* (_____) _____ - _____ **Cell Phone:** *(Telefono Mobil)* (_____) _____ - _____

Email Address: *(correo electronico)* _____

Emergency Contact & Telephone: _____
(Nombre y Telefono de Emergencia)

What is your race?*(¿Cuál es su raza?)* **Please mark one or more:** *(Por favor, marque uno o más)*
( ) **White** *(Anglosajon))* ( ) **American Indian or Alaska Native** *(Indio Americano o Nativo de Alaska)* ( ) **Asian** *(Asiático)*
( ) **African American** *(Afroamericano* ( ) **Native Hawaiian or Pacific Islander** *(Nativo de Hawai o Isleño del Pacífico)*
( ) **Other** *(Otro)* ( ) **Refuse to report** *(Negarse a informar)*

What is your ethnic origin? *(¿Cuál es su origen étnico?)* ( ) **Latino/Hispanic** *(Latino/Hispano)*
( ) **Not Latino/Hispanic** *(No Latino/Hispano)* ( ) **Refuse to report** *(Negarse a informar)*

Preferred Language? *(¿Idioma preferido?)* _____

Employment Status: *(Condición de empleo)* ( ) **Employed:** *(Es empleado)* ( ) **Student:** *(Estudiante)*
( ) **Child:** *(Menor de Edad)* ( ) **Unemployed:** *(Desempleado)* ( ) **Retired:** *(Retirado)*

Employer: *(Compania Para la Cual Trabaja)* _____ **Occupation:** *(Ocupación)* _____

Employer Address: *(Domicilio de Compania)* _____**City**: *(Ciudad)*_____

State: *(Estado)* _____ **Zip:** *(Zona Postal)* _____**Telephone**: *(Telefono)* (_____) _____ - _____

Referring Doctor: *(Quien es el Doctor que lo Refirio)* _____

Primary Doctor: *(Doctor de Cabecera)* _____

Part of the Body to be Examined: *(Parte del Cuerpo a Examinar)* _____

Right: *(Derecha)* _____ **Left**: *(Izquierda)* _____

Is the Problem Due to an Injury? *(¿Fue el Problema Ocacionado por un Accidente?)* _____

Did it Happen at Work? *(¿Fue Accidente de Trabajo?)* _____ **Did You Report It?** *(¿Lo Reporto?)* _____

Was it an Auto Accident? *(¿Fue Accidente Automobilistico?)* _____

Please Turn Over *(Por Favor, Continua al Reverso)*

PRIMARY INSURANCE *(SEGURO MEDICO PRIMARIO)*

Name of Insurance: *(Nobre del Seguro Medico)* _____ PPO _____ HMO _____

Group Name: *(Nombre del Grupo)* _____ **Number:** *(Numero)* _____

Policy Number: *(Numero del Poliza)* _____

Insured Person: *(Persona Asegurada)* **Self:** *(Yo Mismo)* _____ **Spouse:** *(Esposo/a)* _____

Child: *(Menor de Edad)* _____ **Other:** *(Otro)* _____

Name of Spouse: *(Nombre de Esposo/a)* _____ **Date of Birth:** *(Fecha de Nacimiento)* _____

Employer: *(Compania Para la Cual Trabaja)* _____ **Occupation:** *(Ocupación)* _____

Employer Address: *(Domicilio de Compania)* _____ **City:** *(Ciudad)* _____

State: *(Estado)* _____ **Zip:** *(Zona Postal)* _____ **Telephone:** *(Telefono)* (_____) _____ - _____

IF THE PATIENT IS A CHILD *(SI EL PACIENTE ES MENOR DE EDAD)*

Name of Father: *(Nombre y Apellido del Padre)* _____ **Date of Birth:** *(Fecha de Nacimiento)* _____

Address if Different: *(Domicilio)* _____

Employer Address: *(Domicilio de Compania)* _____

City: *(Ciudad)* _____ **State:** *(Estado)* _____ **Zip:** *(Zona Postal)* _____

Telephone: *(Telefono)* (_____) _____ - _____ **Occupation:** *(Ocupación)* _____

Name of Mother: *(Nombre y Apellido del Madre)* _____ **Date of Birth:** *(Fecha de Nacimiento)* _____

Address if Different: *(Domicilio)* _____

Employer Address: *(Domicilio de Compania)* _____

City: *(Ciudad)* _____ **State:** *(Estado)* _____ **Zip:** *(Zona Postal)* _____

Telephone: *(Telefono)* (_____) _____ - _____ **Occupation:** (Ocupación) _____

SECONDARY INSURANCE *(SEGURO MEDICO SECUNDARIO)*

Name of Insurance: *(Nobre del Seguro Medico)* _____ **Insured Person:** *(Persona Asegurada)* _____

Policy Number: *(Numero del Poliza)* _____ **Group # :** *(#Grupo)* _____

By signing below, I authorize the physician and office staff to furnish information to insurance carriers concerning this illness or injury, and hereby irrevocably assign to the physician all payments for medical services rendered.
(Yo autorizo al medico a proporcionar informacion a la aseguradora en relacion a esta enfermedad o accidente e irrevocablemente asigno al medico todos los pagos por los servicios medicos recividos.)

I understand that I am financially responsible for all charges, whether or not covered by my insurance.
Comprendo que soy financilmente responsible por todos los cargos sean o no sean cubiertos por el seguro medico)

There will be a $25.00 charge on any missed appointments without a 24 hour notice.
(Habra un cobro de $25.00 por citas perdidas sin previo aviso de 24 horas.)

Signed: *(Firme)* _____ **Date:** *(Fecha)* _____

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HIPAA Notice of Privacy Practices:

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (619) 426-3240.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

William C. Eves, M.D., Inc.
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Authorization to Release Information to Family Members

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. The Health Insurance Portability and Protection Act (HIPPA) require that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

The following are authorized to receive all of my medical record information:

	Name of Person	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____

Patient's Name: _____

Patient's Signature: _____ Date: _____

480 Fourth Avenue, Suite 307 • Chula Vista, CA 91910 • Phone: (619) 426-3240 • Fax: (619) 426-5964

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Financial Responsibility Policy

It is the policy of this office that all patients, or their guarantors are financially responsible for the services provided by William Eves MD, Inc. Our office expects any co-payments that are required from your health insurance to be paid at the time of service. The patient will be responsible for any portion of the bill that is not covered by their insurance carrier.

If your health insurance requires that you have a referral from your Primary Care Physician, it is ultimately your responsibility to check that our office has received that referral before your visit. If we have not received your referral by the time of your visit, you will need to reschedule your appointment, or you will be responsible to pay for the services that are provided at that appointment.

Should you lose your health insurance, you will be responsible to pay for the provided services that you receive.

I do hereby understand and agree with the financial policy of William Eves MD, Inc.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Guarantor (if necessary): _____

Relationship to patient: _____

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Print in Color or Grayscale Only
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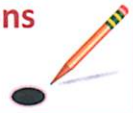
Reason for Visit

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered MANUALLY.

Marking Instructions

Please use a # 2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

What is the PRIMARY area of the body that you are seeing the doctor for today?

- shoulder
- arm
- elbow
- forearm
- wrist
- hand
- neck
- low back
- hip
- thigh
- knee
- leg
- ankle
- foot
- other: _____

What side is the problem? right ○ left ○ both ○

Are you having?

- pain
- swelling
- instability
- numbness
- other: _____

How long have you had this problem? _____ days ○ weeks ○ months ○ years ○

Describe: _____

Did you have an injury? yes ○ no ○ **Date?** _____

Describe: _____

Did this injury happen while at work? yes ○ no ○

Describe: _____

Are you currently having pain? yes ○ no ○

How much pain on a scale of 0 to 10?

☺ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ ☹

What type of pain?

- sharp
- ache
- burning
- other: _____

What is the frequency of the pain?

- intermittent
- constant
- at night
- other: _____

What activities aggravate the pain?

- walking
- sitting
- running
- bending
- standing
- other: _____
- overhead activities

What relieves your pain?

- acupuncture
- massage
- pain medicine
- other: _____

Do you have numbness or tingling? yes ○ no ○

Describe: _____

Have you had x-rays? yes ○ no ○ **When?** _____

Where?

- Sharp
- Scripps
- Imaging Healthcare
- Paradise Valley
- Balboa
- other: _____

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Reason for Visit

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered MANUALLY.

Have you had an MRI? yes ◯ no ◯ When? _____

Where?

◯ Sharp ◯ Imaging Healthcare ◯ Balboa
◯ Scripps ◯ Paradise Valley ◯ other: _____

Have you had any other tests? yes ◯ no ◯

What type? _____ When? _____

Have you been treated for this problem? yes ◯ no ◯

Have you had physical therapy? yes ◯ no ◯

Where? _____ When? _____

Have you had any injections? yes ◯ no ◯ When? _____

What type? ◯ Cortisone ◯ other: _____

Have you been treated with medications? yes ◯ no ◯

What? _____

Any other type of treatment? yes ◯ no ◯ When? _____

What? _____

Do you have any other concerns that you would like to discuss with the doctor today? yes ◯ no ◯

Describe: _____

_____

MEDICATIONS AND ALLERGIES

Do you take any medications? yes ◯ no ◯

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

Do you take any blood thinning medications? yes ◯ no ◯

If yes, check one: Coumadin ◯ Plavix ◯ other ◯ Please specify: _____

Do you have any allergies to medications? yes ◯ no ◯

Name of Medication	Reaction

What is your current height? _____ What is your current weight? _____

Thank you for your time in completing this questionnaire.

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Personal and Family History

Please answer every question.

STAFF: Handwritten responses must be entered MANUALLY.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil.
Fill in the complete oval as shown...

SOCIAL HISTORY

What is your occupation? _____ **How long?** _____

TOBACCO USE

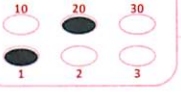
Do you smoke? current (every day) ○ current (some days) ○ previous ○ never ○

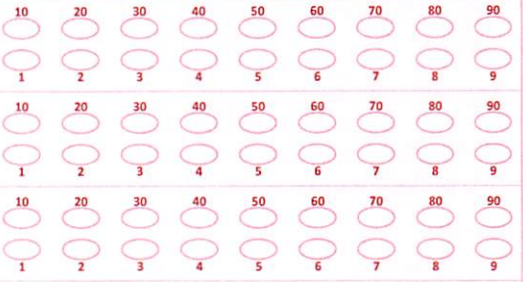
At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke or did you previously smoke per day?

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:





Are you exposed to passive (second hand) smoke? yes ○ no ○

ALCOHOL USE

Do you drink alcohol? yes ○ no ○

What type(s) of alcohol do you drink? beer ○ wine ○ other ○

How many per day? 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

PAST MEDICAL HISTORY

Do you have, or have you ever had any of the following?

- ○ high blood pressure
- ○ heart disease
- ○ emphysema
- ○ liver disease
- ○ high cholesterol
- ○ DVT
- ○ bleeding disorder
- ○ thyroid disease
- ○ seizures
- ○ gastritis
- ○ drug addiction
- ○ blood transfusions
- ○ depression
- ○ HIV
- ○ cancer what type? _____
- ○ stroke
- ○ lung disease
- ○ asthma
- ○ hepatitis
- ○ diabetes
- ○ blood clots
- ○ kidney disease
- ○ anemia
- ○ epilepsy
- ○ ulcers
- ○ arthritis
- ○ gout
- ○ anxiety
- ○ tuberculosis
- ○ **NONE of the above**

Do you have a cardiac stent? yes ○ no ○

Do you have a cardiologist? yes ○ no ○

Cardiologist name: _____

Do you have any other medical problems? yes ○ no ○

What? _____

FAMILY MEDICAL HISTORY

Do you have a FAMILY HISTORY of any diseases?

- ○ **Family history UNKNOWN**
- ○ heart disease
- ○ lung disease
- ○ high blood pressure
- ○ high cholesterol
- ○ thyroid disease
- ○ bleeding disorder
- ○ depression
- ○ anxiety disorder
- ○ cancer what type? _____
- ○ diabetes
- ○ blood clots
- ○ stroke
- ○ liver disease
- ○ kidney disease
- ○ tuberculosis
- ○ ulcers
- ○ arthritis
- ○ other _____
- ○ **NONE of the above**

Are your parents living? yes ○ no ○

If no, cause of death? _____ **Age at death?** _____

Thank you for your time in completing this questionnaire

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Surgeries

Please answer every question.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

Please mark all surgeries you have had.

○ I have had **NO SURGERIES** *(No need to complete questionnaire.)*

○ Anal Fissure Repair	○ Low Back Disc Surgery	○ Tonsillectomy	○ Deviated Nose Septum
○ Appendectomy	○ Neck Disc Surgery	○ Ulcer Surgery	○ Tubal Ligation
○ Hemorrhoidectomy	○ Sinus Surgery	○ Vasectomy	

Prostate Surgery	○ TURP	○ Removal		
Gallbladder Surgery	○ Open	○ Laparoscopic		
Colon Polyp Removal	○ Open	○ Colonoscopy		
Colon Removal	○ Partial	○ Complete		
Hysterectomy *(due to cancer)*	○ Partial	○ Complete		
Hysterectomy *(not due to cancer)*	○ Partial	○ Complete		
Spinal Fusion	○ Neck	○ Lower Back		
Spinal Decompression	○ Neck	○ Lower Back		
Dilation and Curettage (D&C)	○ Single	○ Multiple		
Lung Surgery	○ Left	○ Right	○ Both	
Kidney Removal	○ Left	○ Right	○ Both	
Cataract Surgery	○ Left	○ Right	○ Both	
Breast Cancer Lump Removal	○ Left	○ Right	○ Both	
Mastectomy	○ Left	○ Right	○ Both	
Breast Reconstruction	○ Left	○ Right	○ Both	
Breast Reduction	○ Left	○ Right	○ Both	
Ovary Removal	○ Left	○ Right	○ Both	
Carpal Tunnel Surgery	○ Left	○ Right	○ Both	
Rotator Cuff Repair	○ Left	○ Right	○ Both	
Arthroscopic Shoulder Surgery	○ Left	○ Right	○ Both	
Hip Fracture & Surgery	○ Left	○ Right	○ Both	
Total Hip Replacement	○ Left	○ Right	○ Both	
Total Knee Replacement	○ Left	○ Right	○ Both	
Arthroscopic Knee Surgery	○ Left	○ Right	○ Both	
Foot Surgery	○ Left	○ Right	○ Both	
Varicose Vein Procedure	○ Left	○ Right	○ Both	
Mastoidectomy	○ Left	○ Right	○ Both	
Thyroid Removal	○ Left	○ Right	○ Total	○ Partial
Breast Biopsy	○ Left	○ Right	○ Both	○ Multiple times
Carotid Artery Surgery	○ Left	○ Right	○ Both	○ Multiple times
Open Inguinal Hernia Surgery	○ Left	○ Right	○ Both	○ Multiple times
Laparoscopic Inguinal Hernia Surgery	○ Left	○ Right	○ Both	○ Multiple times
Caesarean Section	○ 1	○ 2	○ 3 or More	
Heart Valve Replacement	○ Mitral	○ Aortic	○ Tricuspid	○ Unknown Valve
Heart Bypass Surgery	○ 1 Vessel	○ 2 Vessels	○ 3 Vessels	○ 4 or More Vessels
	○ Unknown Number of Vessels			

○ **Other Surgery** *If yes, please specify type, where and when*:

_____

_____

Have you ever been hospitalized? ○ Yes ○ No

If yes, please specify where and when:

_____

_____

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Review of Systems

Please answer every question.

STAFF: Handwritten responses must be entered MANUALLY.

Marking Instructions

Please use a # 2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please mark only the symptoms you are CURRENTLY experiencing:

Mark all that apply. If no symptoms, please mark "NONE."

GENERAL
fevers ○ chills ○ fatigue ○ weight loss ○ NONE ○

EYES
eye pain ○ loss of vision ○ NONE ○

EAR / NOSE / THROAT
impaired smell ○ loud snoring ○ difficulty swallowing ○ hearing problems ○ NONE ○

CARDIOVASCULAR
chest pain ○ palpitations ○ NONE ○

RESPIRATORY
shortness of breath ○ cough ○ NONE ○

GASTROINTESTINAL
abdominal pain ○ constipation ○ diarrhea ○ nausea ○ NONE ○

GENITOURINARY
bladder infections ○ urinary problems ○ NONE ○

MUSCULOSKELETAL
muscle pain ○ muscle cramps ○ swelling ○ weakness ○ NONE ○

SKIN
skin rashes ○ dry skin ○ NONE ○

NEUROLOGICAL
headaches ○ seizures ○ dizziness ○ numbness ○ NONE ○

PSYCHIATRIC
anxiety ○ depression ○ NONE ○

HEMATOLOGIC / LYMPHATIC
bleeding problems ○ anemia ○ NONE ○

OTHER SYMPTOMS / EXPLAIN
please list: _____

Thank you for your time in completing this questionnaire.