

My Medical History Page 1

Name	Age	Height	Weight	Today's Date

Medications I am currently taking:		<input type="checkbox"/> I am currently taking no medications regularly	
Medication	Dosage (mg)	How often	I take it for my:

Medical conditions that I have:		<input type="checkbox"/> No medical problems I know of	
<input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart problems <input type="checkbox"/> Heart attack <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood clot formation/DVT <input type="checkbox"/> Blood flow problems	<input type="checkbox"/> Stomach ulcers/gastritis <input type="checkbox"/> Stomach reflux/GERD <input type="checkbox"/> Irritable bowel/IBS <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Prostate problems/BPH <input type="checkbox"/> Liver problems/hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Cancer of:	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteoporosis/brittle bones <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Neuropathy <input type="checkbox"/> Depression <input type="checkbox"/> Alzheimer's
Other medical problems I have/more info:			

Allergies I have to medications:		<input type="checkbox"/> I have no known allergies to any medications	
Medication	Type of reaction I had (rash, nausea, stopped breathing, etc.)		

Operations I have undergone in the past:		<input type="checkbox"/> I have had no major operations in the past	
<input type="checkbox"/> Appendectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Vasectomy <input type="checkbox"/> C-Section	<input type="checkbox"/> Heart surgery <input type="checkbox"/> Cardiac catheterization <input type="checkbox"/> Cardiac stent placement <input type="checkbox"/> Colonoscopy/endoscopy	<input type="checkbox"/> Previous bone or joint orthopaedic surgery:	
Other Surgeries I have undergone/more info:			

Family Medical History:		<input type="checkbox"/> No medical problems in my family I know of	
Medical problem:	In my (mother, father, etc.):	Medical problem:	In my: (mother, father, etc.):
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Heart problems		<input type="checkbox"/> Other joint problems	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Osteoporosis/brittle bones	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Neuropathy	
<input type="checkbox"/> Blood clot formation/DVT		<input type="checkbox"/> Stroke/TIA/CVA	
<input type="checkbox"/> Bleeding problems		<input type="checkbox"/> Problems with Anesthesia	
<input type="checkbox"/> Cancer of:		<input type="checkbox"/> Other:	

I am active in:

<input type="checkbox"/> No specific sports or exercise	<input type="checkbox"/> Cycling	<input type="checkbox"/> Basketball	<input type="checkbox"/> Gymnastics
<input type="checkbox"/> Walking for fitness	<input type="checkbox"/> Mountain biking	<input type="checkbox"/> Golf	<input type="checkbox"/> Skiing
<input type="checkbox"/> Exercising at the gym	<input type="checkbox"/> Hiking	<input type="checkbox"/> Tennis	<input type="checkbox"/> Snowboarding
<input type="checkbox"/> Weight training	<input type="checkbox"/> Baseball/Softball	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Dance/cheer
<input type="checkbox"/> Running	<input type="checkbox"/> Soccer	<input type="checkbox"/> Lacrosse	<input type="checkbox"/> Other:
<input type="checkbox"/> Swimming	<input type="checkbox"/> Football	<input type="checkbox"/> Hockey	

Alcohol Use:

<input type="checkbox"/> None/ rarely
<input type="checkbox"/> 1-2 drinks/week
<input type="checkbox"/> 1-2 drinks/day
<input type="checkbox"/> Three or more drinks/day
<input type="checkbox"/> Difficulty with heavy alcohol use in the past

Tobacco use:

<input type="checkbox"/> I don't smoke
<input type="checkbox"/> I quit in _____ after smoking _____ packs/day for _____ years
<input type="checkbox"/> ½ to 1 pack/day
<input type="checkbox"/> 2 or more packs/day

Recreational drug use:

<input type="checkbox"/> None
<input type="checkbox"/> Occasionally
<input type="checkbox"/> Regularly
<input type="checkbox"/> Drugs I commonly use:

Here's why I want to get this treated:

<input type="checkbox"/> relief from the pain	<input type="checkbox"/> get back to exercising, like:
<input type="checkbox"/> get back to normal day to day living	<input type="checkbox"/> get back to sports, like:
<input type="checkbox"/> heavy work on the job	

Review of systems:

I commonly experience (check only if yes)

None of the below:

<input type="checkbox"/> Seasonal allergies/hay fever <input type="checkbox"/> Dermatitis <input type="checkbox"/> Frequent itching <input type="checkbox"/> Skin reactions <input type="checkbox"/> Reactions to Latex/rubber gloves <input type="checkbox"/> Runny nose Describe: <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Weakness all over Describe: <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Rapid heart beats <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> High blood pressure Describe: <input type="checkbox"/> Changes in skin color <input type="checkbox"/> Skin rashes <input type="checkbox"/> Skin masses <input type="checkbox"/> Skin sores/ulcers <input type="checkbox"/> Skin cancers Describe: <input type="checkbox"/> Frequent thirst <input type="checkbox"/> Frequent hunger <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Hypoactivity <input type="checkbox"/> Growth changes <input type="checkbox"/> Hair changes Describe:	<input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Dizziness <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sinusitis Describe: <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Easy bruising <input type="checkbox"/> Lymph node enlargement <input type="checkbox"/> Anemia Describe: <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach ulcers/reflux <input type="checkbox"/> Heartburn/indigestion <input type="checkbox"/> Appetite change <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Loss of appetite Describe: <input type="checkbox"/> Bone fractures <input type="checkbox"/> Joint sprains <input type="checkbox"/> Joint swelling <input type="checkbox"/> Low back pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Fibromyalgia Describe:	<input type="checkbox"/> Headaches <input type="checkbox"/> Speech difficulty <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Numbness, tingling <input type="checkbox"/> Seizures/epilepsy <input type="checkbox"/> Balance problems, falls Describe: <input type="checkbox"/> Double vision <input type="checkbox"/> Blurry vision <input type="checkbox"/> Eye trauma <input type="checkbox"/> I wear glasses/contacts Describe: <input type="checkbox"/> Mood swings <input type="checkbox"/> Sleep problems <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Substance abuse <input type="checkbox"/> Heavy alcohol use/drinking Describe: <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic lung problems <input type="checkbox"/> Chronic cough Describe: <input type="checkbox"/> Difficulty passing urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Painful menstruation/PMS Describe:
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DAVID M. BELL, M.D. ORTHOPAEDIC SURGERY & SPORTS MEDICINE
5924 STONERIDGE DRIVE, SUITE 202 PLEASANTON, CA 94588 925-600-7020 BELLSPORTMED.COM

Consent to Treat

I hereby acknowledge that I or the child entrusted to me need medical care and treatment, and I authorize and consent to the Bell Sports Medicine Division of Bay Area Surgical Specialists, Inc. and its physicians and providers to perform medical services. I consent to the use of diagnostic and therapeutics means to treat the medical condition, including but not limited to examination, radiographs, local anesthetics, injections, bracing, casting, laboratory tests, physical therapy and diagnostic imaging.

Assignment of Benefits

I hereby assign and transfer to the Bell Sports Medicine Division of Bay Area Surgical Specialists, Inc., the benefits, monies and sums or other credits payable to myself or child for treatment of their medical condition, or other insurance policy, or any other state, federal or private insurance policy which might be applied toward payment of or reimbursement for any and all services rendered or goods supplied as a result of treatment contemplated by this agreement. If for any reason I am unable to assign or transfer such rights, I hereby authorize and appoint Bay Area Surgical Specialists, Inc. as my agent with respect to the pursuance, receipt and application of such funds as it sees fit.

I understand that I am financially responsible to pay in full in the event that my health insurance does not reimburse in full for services rendered.

Medicare Authorization: I certify this information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Bell Sports Medicine, Inc., and its physicians and providers rendering service during my treatment(s).

I understand that Bay Area Surgical Specialists, Inc., does not participate in the Medi-Cal program, and that patients will be financially responsible for services rendered.

I understand that I may be referred for professional services to other facilities and physicians and providers that are not employees or agents of Bay Area Surgical Specialists, Inc. Examples would include outpatient surgery centers, hospitals, anesthesiologists, physical therapists, medical supply companies, cryotherapy unit companies, MRI facilities and laboratories. Bay Area Surgical Specialists, Inc. is not responsible for the acts or omissions of these facilities or practitioners. The financial relationship will be between the patient and the facility or provider and not the Bell Sports Medicine Division of Bay Area Surgical Specialists, Inc.

Authorization to use or disclose my health information

Note: This is a legal requirement for patient privacy. Your medical information will not be used for marketing purposes.

I have read and reviewed the Notice of Privacy Practices.

Bay Area Surgical Specialists, Inc. may use or disclose the following health care information:

None OR All my health information maintained by Bell Sports Medicine Institute, Inc.

Bay Area Surgical Specialists, Inc. may disclose this information only to:

No one OR Person(s) specified to receive information: _____ Relationship: _____

Signature: I agree to all the above and the attached notices

Signature Print Name Relationship (if signing for minor) Date



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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 this 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" (PHI) 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 health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your PHI 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 PHI 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, your PHI may be provided to a physician to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

Payment: Your PHI 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 PHI be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. The activities include, but are not limited to, quality assessment activities, employee review activities, training programs licensing, and conducting or arranging for other business activities. For example, we may use a sign-up 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 PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization as required by law: Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements. Legal proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations, 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 Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

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 physician's practice has taken action in the reliance on the use or disclosure indicated in the authorization.

Patient Rights

Following is a statement of your rights with respect to PHI:

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of sue in a civil, criminal, or administrative action of proceeding, and PHI that is subject to law that prohibits access to PHI. We may request a reasonable fee for copying your records.

You have the right to request restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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 list 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 the physician believes it is in your best interest to permit use and disclosures of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communication from us by alternative means or at an alternative location. Upon your request, you have the right to obtain a paper copy of this Notice from us even if you have agreed to accept this Notice alternatively, such as electronically.

You may have the right to have your physician amend your PHI. If your physician denies 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 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 or certain disclosures we have made, if any, of your PHI. 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 the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. To file a complaint with DHHS, call 877-696-6775. You may file a complaint with us by notifying our privacy officer, our office manager of your complaint. We will not retaliate against your complaint.

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 PHI. If you have any objections to this Notice, please ask to speak with our HIPAA Compliance Officer, our office manager, in person or by phone 925-600-7020.

Effective Date April 14, 2003.

Forms Policy

In order to cover the costs of processing forms you bring to our office for us to complete, we ask for a **\$20 fee per form** to be paid at the time you drop them off with us. Please be advised that it will take our office three business days to complete the forms. We ask that you do not contact our office to determine if they have been completed, as this takes away from our valuable time with patients. We will contact you when your papers are ready to be picked up.

This section is mandated by the State of California

Notice to Consumers:

Medical Doctors are licensed and regulated by the Medical Board of California.

(800) 633-2322 www.mbc.ca.gov

I acknowledge that I understand that physicians are licensed and regulated by the Medical Board of California.