PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____CITY _____STATE _____ ZIP _____

HOME NUMBER_____WORK NUMBER_____ CELL _____

EMAIL ADDRESS _____ SEX (circle): Male Female

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____CITY _____ STATE _____ ZIP_____

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

EMERGENCY CONTACT

EMERGENCY CONTACT _____PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____PHONE _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
_____

BIRTHDATE OF INSURED: _____POLICY # _____GROUP # _____

SECONDARY INSURANCE _____PHONE _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
_____

BIRTHDATE OF INSURED: _____POLICY # _____GROUP # _____

FAMILY DOCTOR OR INTERNIST

FAMILY DOCTOR'S NAME _____ PHONE #_____

REFERRING PHYSICIAN

REFERRING PHYSICIAN_____ PHONE #_____

AUTHORIZATION

I hereby authorize the physician to furnish information to insurance carrier regarding this illness/accident, and hereby irrevocably assign to Dr. Penenberg all payments for medical services rendered. A copy of this authorization shall be considered valid as the original.

PATIENT SIGNATURE_____ DATE _____

_____

Brad L. Penenberg, M.D.
Michelle Riley, PA-C Jennifer Lo, PA-C

INSURANCE ACKNOWLEDGEMENT

Patient's Name: _____

Insurance Plan: _____

We are contracted providers with Medicare. However, please be aware that Dr. Brad Penenberg, Michelle Riley, PA-C and Jennifer Lo, PA-C are not contracted providers with PPO/HMO insurance companies. As a courtesy to our patients, we will submit a claim for services rendered in our office to your insurance.

Even though we do not participate in your insurance plan, it is usually possible to work out an acceptable financial arrangement.

Please feel free to contact our billing service, Med-Net Billing, at (310) 322-4278 to discuss these arrangements.

X_____ _____

Patient's Signature Date

HIPAA COMPLIANCE PLAN/ MEDICAL RECORDS RELEASE FORM FOR
BRAD L. PENENBERG, M.D., INC.

Expiration Date of Authorization
This authorization is effective through ____/_____/_____ unless revoked or terminated earlier by the patients or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our practice. You should contact our Privacy Office to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual
You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization,

Effect of Refusing Authorization
If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

_____
Treatment Conditioned on Authorization

_____
Printed Name of Patient

X_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship to Patient

Information to Be Used or Disclosed
The information covered by this authorization includes
_____

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:
_____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

_____

Name of person/organization

PATIENT NAME: _____ DATE OF BIRTH:_____

1. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices for the medical practice of Brad L. Penenberg, M.D., Inc. Our practice reserves the right to modify the privacy practices outlined in the notice.

   Please initial: x_____

2. AUTHORIZATION TO RELEASE INFORMATION: I agree that my physician and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to and to make copies of my medical records.

   Please initial: x_____

3. AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign all medical benefits payable to me to be paid directly to Brad L. Penenberg, M.D., Inc. any monies payable to Dr. Penenberg will be paid directly to him.

   Please initial: x_____

4. NON-CANCELLED APPOINTMENTS: I understand that when I make an appointment and do not cancel within 24 hours of said appointment, I will be charged $25.00 because another patient could have been given that appointment time.

   Please initial: x_____

5. FINANCIAL AGREEMENT: I hereby agree to pay all statements not covered by insurance for services rendered by the physicians and medical staff at the end of each medical service. Any balance not paid within 30 days of receipt of statement will be considered in default, unless financial arrangements have been made with Med-net, our billing service.

   Please initial: x_____

6. SPECIAL LETTERS/FORMS/MEDICAL RECORDS COMPLETION: I understand that EDD, DMV placard, airport, and jury duty forms are completed by the staff at no charge. If I request a letter regarding medical conditions, family leave, life insurance forms or Aflac forms, I will be charged a minimum of $25.00. A copy of medical records to be picked up will cost $25. Faxed or mailed medical records will cost $35.

   Please initial: x_____

7. DISCLOSURES: I understand that Dr. Penenberg is a consultant for, and receives royalties from, Microport, Inc. for his input on orthopaedic implant design, surgical instrumentation and surgical techniques. Specific implant choice is based on patient specific needs and if I have surgery performed

by Dr. Penenberg, I understand that I may receive an implant from this company or another orthopaedic device company to which he has no financial connection. Further details available upon request.

Please initial: x

The undersigned certifies that he/she has read the foregoing, receiving a copy if requested thereof, and is the patient or is authorized by the patient's general agent to execute the above and accept its terms.

X _____ _____

Signature Date

PLEASE CIRCLE/ANSWER ALL THAT APPLIES

PATIENT NAME: _____ DATE _____

Pain: Yes/No **Pain scale**: 0 1 2 3 4 5 6 7 8 9 10/10 **Onset:** _____ years _____months

Duration: comes & goes/constant **Support**: none/brace/cane/crutch/walker/wheelchair_____

Character of Pain: slight/mild/moderate/severe/dull/sharp/stabbing/burning/night pain

Location of Pain: **Hip**: groin/side/butt_____ **Knee**: front/back/inside/outside_____

Walking distance: unlimited/30 minutes/15 minutes/indoors only/bed and chair only _____

Limp: none/mild/moderate/severe **Diff. putting on shoes and socks**: with ease/difficulty/unable

Stairs: with ease/no rail/rail/avoids **Pain with chair rising**: Yes/No **Instability**: Yes/No

Falls: Yes/No. If yes, how often_____ **Weight**: gain/loss **Swelling**: Yes/No

Do you feel that one leg is longer than the other? If yes, which leg feels longer: Left or Right

Medications for pain:
ASA/Tylenol/Advil/Aleve/Mobic/Celebrex/Relafen/Vicoden/Tramadol/other:_____
_____

Contraindications to treatments: Yes/No: GI bleed, allergy to medications, kidney/liver disease:
_____

Injections: Cortisone/viscosupplementation/PRP. Yes/No. If yes, when/location of injection and was relief obtained?_____

Physical Therapy: Yes/No. If yes, when and relief with
treatment:_____

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Contradictions to therapy: Pain/heart disease_____

Recent X-rays/MRI/CT: Yes/No. If yes, where was study performed:

_____

What do you do for exercise:

_____

Alleviating Factors: ice/heat/meds/rest _____

Associated Accidents to the knee/hip: Yes/No If yes, please describe_____

_____

Previous Surgery to the Hip/Knee: Please indicate surgeon and location of hospital.

_____

_____

CURRENT MEDICAL HISTORY: Height: _____ ft ____ in Weight: _____ lbs

Pharmacy Name & Phone #: _____

Please list current medications: _____

_____

Please list any medications or substances to which you are allergic, including any metals: _____

_____

Are you currently taking blood thinning medications? NO YES

Are you currently taking cortisone-type medications? NO YES

Have you or any blood relative ever had a major adverse reaction to anesthesia? NO YES

Have you ever had any blood/vascular disorders (blood clots, stroke, heart attack, bleeding disorder, anemia)? NO YES

Do you consume alcohol? NO YES

Do you currently or have you ever smoked cigarettes or other tobacco products? NO YES
If so, for how long, and how many? _____

Are you currently or gave you ever been addicted or habituated to drugs? NO YES
If so, which drug(s)? _____

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Are you on any special or restricted diet? NO YES If so, what type? _____

FAMILY HISTORY: Have any blood relatives ever had any of the following (or other disease)? Heart disease, high blood pressure, diabetes, cancer, stroke, tuberculosis, gout, bone disease, other? If so, what disease and who?

SURGICAL HISTORY: Please list date, procedure, surgeon, and hospital:

MAJOR ACCIDENTS OR INJURIES: Please list date, type of injury, and treatment:

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE INDICATE BY CIRCLING THE APPROPRIATE ITEM:

GENERAL
fever, sweats
recent marked weight loss or gain

GASTROINTESTINAL
ulcers or gastritis
severe or frequent abdominal pain
tarry black stool
yellow jaundice
coffee ground vomiting

HIV/AIDS
ever exposed to AIDS?
used self-procured IV drugs?
When?
Results?

NEUROLOGICAL
fainting

CARDIAC
high blood pressure
history of heart attack
chest pain
shortness of breath
rapid or irregular pulse
ankle swelling

HEAD, EYES, EARS, NOSE
frequent headaches
neck pain or stiffness
glaucoma
eye pain
blurring of vision
double vision
unusual sensitivity to light
discharge from eyes
hearing difficulties
sinus problems

ENDOCRINE
diabetes
thyroid disorder
gout

GENITOURINARY
frequent or painful urination
kidney or bladder infection
kidney stones

HEMIC-LYMPHATIC
easy bruising
prolonged bleeding
frequent minor infection

MUSCULOSKELETAL
generalized joint pain
joint swelling
neck or back pain

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convulsions
dizziness
shakiness or trembling

VASCULAR
previous phlebitis
leg cramps on exercise
varicose veins

PSYCHIATRIC
under psychiatric care
serious emotional problems
history of substance abuse

WOMEN
pregnant
abnormal/irregular periods
vaginal discharge
date of last period _____
age at which period stopped: _____

RESPIRATORY
asthma
chronic cough
sputum producing cough
coughing up blood
positive TB skin test
abnormal chest x-ray