IRVINE ORTHOPEDICS
Empowering Motion

Dr. Darius E. Lin
22 Odyssey Suite 270B
Irvine CA 92618
949-431-2668

PATIENT REGISTRATION

PATIENT INFORMATION				
NAME *Last*	*First*	*MI*	BIRTHDAY	SEX M F
ADDRESS		CITY, STATE		ZIP
HOME PHONE	CELL PHONE		EMAIL	
PREFERRED LANGUAGE	SSN		MARITAL STATUS	
RACE ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ HISPANIC OR LATINO ☐ ASIAN ☐ MIDDLE EASTERN ☐ OTHER_____			ETHNICITY	
EMERGENCY CONTACT				
NAME		RELATIONSHIP TO PATIENT		
CELL PHONE				

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Irvine Orthopedics or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

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HEALTH HISTORY

Name:___ Date:_____

Height:_____ **Weight**:_____ Date of Birth:_____

Reason for the visit:_____

_____

Referred by: ☐ Friends ☐ Family ☐ Online ☐ Primary Care Physician ☐ Urgent Care ☐ Other: _____

Primary Care Physician: _____

If applicable, Cardiologist: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Past Medical History

Do you have or have you ever had any of the following? (*check if yes*)

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Pulmonary Disease
- ☐ Autoimmune Disease
- ☐ Blood Clot
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Psychiatric History
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis

Other Conditions: _____

_____

_____

Past Surgical History: _____

_____

_____

List all medications and dosage currently taking, including blood thinners, supplements

_____

_____

_____

_____

List all allergies and reaction (*medications, food, metal*)

_____

_____

_____

Have you ever smoked? ☐ YES ☐ NO If Yes, how much and how often_____ If you quit, how long ago? _____

Do you drink alcohol? ☐ YES ☐ NO If Yes, how many drinks a week? _____

If Yes, has anyone ever told you to cut down on your drinking? ☐ YES ☐ NO

Have you ever you used recreational drugs, including marijuana. ☐ YES ☐ NO If yes, please list _____

_____ _____

Physician Initials Date Reviewed

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Review of Systems

Do you CURRENTLY have any problems in the following areas?
…….If yes, please CIRCLE or provide details

	YES	NO
Constitutional Weight gain or loss Fatigue Weakness Fever	☐	☐
EYES Loss of vision Altered vision Itchy eyes	☐	☐
Ears-Nose-Mouth-Throat Loss of hearing Nosebleeds Sinus problem Sores in mouth Sore throats Difficulty swallowing	☐	☐
Cardiovascular Chest pain Irregular heart beat High blood pressure Difficulty breathing walking up stairs	☐	☐
Musculoskeletal Joint pain Muscle stiffness Muscle weakness Back pain Joint swelling	☐	☐
Gastrointestinal Nausea Vomiting Abdominal pain Diarrhea Blood in stool Jaundice Constipation	☐	☐
Genitourinary Difficult urination Pain or burning urination Blood in urine Discharge from genital	☐	☐
Respiratory Shortness of breath Difficulty breating Wheezing Coughing Coughing up blood	☐	☐
Skin Easy bruising Rash, itching Hives Nodes and bumps Discolouration	☐	☐
Neurological Numbness Headache Dizziness Fainting spells Tremors Weakness Muscle spasm	☐	☐
Blood/Lymph Transfusion Swollen Glands Anemia Prolong bleeding Low blood count Leukemia/lymphoma	☐	☐
Psychiatric Depression Anxiety Disorientation Hallucination Disorientation	☐	☐
Endocrine Frequent urination Thyroid problems (fatigue, hair loss, hot/cold intolerance)	☐	☐
Allergic/Immunologic Infection Drug sensitivity Hives, itching	☐	☐

Physician Initials _____ Date Reviewed _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April,15 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA:
Or to file a complaint:
The U.S Department of Health &
Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C, 20201
202-619-0257
Toll Free: 877-696-6775

Please contact us for more information:
Darius E. Lin, Inc.
Irvine Orthopedics
22 Odyssey Suite 270B
Irvine, CA 92618
949-431-2668

I have received a copy of the Notice of Privacy Practices for Darius E. Lin, Inc. Irvine Orthopedics, as required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand that this organization reserves the right to modify the Privacy Practices outlined in this notice

Patient/Guardian signature _____ Date _____

Witness or Office Personnel _____ Date _____

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CONSENT & ASSIGNMENT OF BENEFITS

INFORMED CONSENT: I consent to the use or disclosure of my health information for the purpose of treatment, payment, and health care operations, including any insurance company, adjustor, or attorney involved in this case. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I hereby acknowledge that I have read, understand and agree to hereby give consent to access, treat and test.

ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance company to pay by check made out and mailed to Darius E. Lin, Inc. and its affiliated Physicians. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
A photocopy of this consent document shall be considered as effective and valid as the original.

Patient/Guardian signature _____ Date _____

Witness or Office Personnel _____ Date _____

WAIVER FORM

Eligibility of coverage for treatment has not been verified. However, I wish to receive medical treatment at this time. I understand that if it is determined that I am not eligible for coverage I will be responsible for all charges that may occur for services provided. I understand you will submit my claims to my insurance company however if you do not receive payment after two attempts, I will be responsible for the balance. I understand that you will supply the necessary paperwork for me to submit my claim to my insurance company so I will be reimbursed for the services rendered. (This does not apply to Medicare patients)Some insurance companies will only pay for services that it determines to be “reasonable and necessary”. Your insurance company may determine that a particular service, although it would be otherwise covered, is not “reasonable and necessary” and your insurance will deny payment for that service. Some insurance companies have notified our office certain procedures are non-covered or investigational according to their policies and therefore deny payment.

I, the undersigned, acknowledge that my physician has informed me that the processing of my claim by my insurance carrier is not a guarantee of payment; therefore, if my claim is denied by my insurance, I agree to be personally and fully responsible for payment to Darius E. Lin, Inc. Irvine Orthopedics. This waiver does not have an expiration date.

Patient/Guardian signature _____ Date _____

Witness or Office Personnel _____ Date _____