

**Basil R. Besh, M.D.**  
SURGERY OF THE HAND, WRIST, AND ELBOW

**Confidential Medical History**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Sex: M / F      Marital Status: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Home Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Preferred Method of receiving confidential communication: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

How did you hear about us?: \_\_\_\_\_

**For office use only:**

Height: \_\_\_\_'\_\_\_\_"    Weight: \_\_\_\_\_ lbs.    BMI: \_\_\_\_\_    BP \_\_\_\_/\_\_\_\_

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**Confidential Medical History (continued)**

Age: \_\_\_\_\_ Hand dominance: Left / Right / Both Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ How long have you worked there? \_\_\_\_\_

Current work status:      FULL DUTY      MODIFIED DUTY      NOT WORKING      RETIRED

Restrictions: \_\_\_\_\_ Date last worked.: \_\_\_\_/\_\_\_\_/\_\_\_\_

What are you here to see the doctor for? \_\_\_\_\_

How did injury occur? \_\_\_\_\_

Is this work related? Y / N      Is this related to an automobile accident? Y / N      Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this the date that the injury occurred, you first noticed symptoms, or you filed a claim? \_\_\_\_\_

How long have you had symptoms? \_\_\_\_\_ Whom have you seen for this condition? \_\_\_\_\_

Please check any studies you

**Doctor's Notes:**

have had and include dates:

\_\_\_\_ X-RAY: \_\_\_\_\_

\_\_\_\_ MRI: \_\_\_\_\_

\_\_\_\_ EMG: \_\_\_\_\_

\_\_\_\_ OTHER: \_\_\_\_\_

Please check any treatment you have had

and include dates / duration / number of visits:

\_\_\_\_ THERAPY: \_\_\_\_\_

\_\_\_\_ SPLINTS/BRACES: \_\_\_\_\_

\_\_\_\_ MEDICATIONS: \_\_\_\_\_

\_\_\_\_ INJECTIONS: \_\_\_\_\_

\_\_\_\_ OTHER: \_\_\_\_\_

(continued)

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**Confidential Medical History (continued)**

In what recreational activities do you enjoy participating?: \_\_\_\_\_

**PAST HISTORY:**

Medical Problems: To the best of your knowledge, have you ever had a serious medical problem related to the following?

Condition	Yes	No	Condition	Yes	No	Please explain ALL yes answers
Skin rashes or disorders	_____	_____	Osteoporosis	_____	_____	_____
Ears, eyes, nose, or throat	_____	_____	Bladder or kidneys	_____	_____	_____
Breasts	_____	_____	Stomach, intestines	_____	_____	_____
Lung disease	_____	_____	Epilepsy or stroke	_____	_____	_____
Heart disease	_____	_____	Thyroid	_____	_____	_____
High blood pressure	_____	_____	Diabetes	_____	_____	_____
HIV, Hepatitis	_____	_____	Cancer	_____	_____	_____
Liver, gallbladder	_____	_____	Blood disorders	_____	_____	_____

Operations	Surgeon	(Year)	Complications

**ALLERGIES:**

**What medications do you take on a daily basis? (PLEASE LIST ALL MEDICATIONS)**

<u>Name</u>	<u>Dose\Frequency</u>	<u>Reason</u>	<u>Name</u>	<u>Dose\Frequency</u>	<u>Reason</u>

**SOCIAL HISTORY:**

1. Do smoked cigarettes? YES / NO / QUIT \_\_\_ Years ago      If YES, how many per day? \_\_\_\_\_ cigarettes
2. How often do you drink alcohol? DAILY / WEEKLY / OCCASSIONALLY / NEVER
3. Do you have any history of substance abuse? YES / NO      If YES, please explain: \_\_\_\_\_

**FAMILY HISTORY:**

What, if any, medical problems do your close relatives have? \_\_\_\_\_

**HISTORY OF PREVIOUS INJURY:**

Have you ever injured this body part before? Y / N If so, how and when? \_\_\_\_\_

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To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information or omitting information may be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status with each and every visit. I also authorize the health care staff to perform the necessary services I may need.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date

**NEW CONDITION FORM  
BASIL R. BESH, MD, INC.**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

LIST AREAS OF CONCERN: \_\_\_\_\_

DATE(S) OF INJURY/LENGTH OF SYMPTOMS: \_\_\_\_\_

DESCRIBE THE ACCIDENT (IF ONE OCCURRED):

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WHEN AND WHAT WERE THE FIRST SYMPTOMS?

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WHAT TREATMENT (IF ANY) HAVE YOU HAD:

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CURRENT SYMPTOMS:

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HAVE YOU HAD SIMILAR PROBLEMS IN THE PAST?

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**John W. Jaureguito, M.D.**  
Orthopaedic Surgery  
Knee, Shoulder & Hip Specialist  
Joint Replacement  
Sports Medicine & Arthroscopy  
510.739.6520

**Jim S. Dhanoa, M.D.**  
Non-Operative Sports Medicine  
Low Back Pain  
Osteoarthritis  
510.739.6520

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Surgery of the Hand and Upper  
Extremity  
Industrial Injuries  
Carpal Tunnel Syndrome  
Athletic Injuries  
Arthritis of the Hand and Wrist  
Golfer's & Tennis Elbow  
510.857.1000

## Our Commitment to Quality Medical Care

Fremont Orthopaedic and Rehabilitative Medicine is committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate your concerns to us or our staff. **Please tell us if you have a complaint or a complement – we value your feedback.**

Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and *greatly* value your feedback. If you would prefer that your comment be anonymous, please find a comment box in our waiting room.

**If we are not able to answer your concern or complaint to your satisfaction, please contact the Alameda-Contra Costa Medical Association.** If you have a complaint and we cannot resolve it together, we can refer you to an impartial dispute resolution committee of our local medical association. As members of the medical association, we have made a commitment to have any complaints you bring against us reviewed by a committee of peers. **Contact ACCMA at 510-654-5383.**

**If the above suggestions are not satisfactory, or for any reason, you may contact the Medical Board of California.** We offer this NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800/633-2322 or [www.mbc.ca.gov](http://www.mbc.ca.gov)).

*I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.*

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Patient/Patient Representative Signature

Date

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Patient/Patient Representative Name – Please Print



FREMONT ORTHOPAEDIC &  
REHABILITATIVE MEDICINE  
39180 Farwell Drive, Suite 110  
Fremont, CA 94538  
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## RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed a copy of the **Notice of Privacy Practices** with the effective date of April 14, 2003.

\_\_\_\_\_  
Signature of Patient/ Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Relationship to Patient (if signing for someone else)

**\*Please complete and sign the Disclosure Form** if you wish anyone else to have access to your records, or if you wish to allow another person to *call* or *pick up* items on your behalf.

If this form is not completed, we will not disclose any information to anyone (example: wife, children, lawyer, etc.)



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**Authorization for the Physicians of FORM to Use or Disclose My Health Information  
RECORD RELEASE/DISCLOSURE FORM**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name (if applicable): \_\_\_\_\_

**I. My Authorization.**

**You may use or disclose the following health care information** (check all that apply):

All my health information maintained by FORM: \_\_\_\_\_

My health information relating to the following treatment or condition: \_\_\_\_\_

My health information for the date(s): \_\_\_\_\_

Other: \_\_\_\_\_

**You may disclose this health information to:**

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Reason (s) for this authorization** (check all that apply):

My request: \_\_\_\_\_ Other (specify): \_\_\_\_\_

**This authorization ends:**

On (date): \_\_\_\_\_ When the following event occurs: \_\_\_\_\_

**II. My Rights.**

I understand that I am not required to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However, I must sign an authorization:

To take part in a research study.      OR

To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by The physicians of FORM, based upon this authorization. I may not be able to revoke this authorization If its purpose was to obtain insurance. Two ways to revoke this authorization are:

Fill out a revocation form (available at the Front Desk).      OR

Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship (parent, legal guardian, etc.)