

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? _____

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):

WHEN AND WHAT WERE THE FIRST SYMPTOMS?

WHAT TREATMENT (IF ANY) HAVE YOU HAD:

CURRENT SYMPTOMS:

HAVE YOU HAD SIMILAR PROBLEMS IN THE PAST?



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).

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.

Patient/Patient Representative Signature

Date

Patient/Patient Representative Name – Please Print



FREMONT ORTHOPAEDIC &
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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.)