Scott f. dye, MD
Orthopaedic Surgery
45 Castro Street
Suite #337
San Francisco, CA 94114

Confidential Information Sheet: (Please Print)

Last Name: _____ First Name: _____ MI _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Drivers License # _____ Date of Birth: _____

Age: _____ SS#_____ Gender: M F Marital Status: M S D W DP

Height_____ Weight_____ Referred By: _____

Emergency Contact: _____ Phone: _____

(Name) (Relation)

Primary Care Physician: _____ Phone: _____

Employment Information:

Employer: _____ Phone: _____

Address: _____ Occupation: _____

Insurance Information:

Insurance Company_____ Group # _____

Billing Address _____

Subscriber Name _____ ID #

_____

Attorney: _____ Phone:

_____

Address: _____ Fax:

_____

I, the undersigned have insurance coverage with _____ and I assign Dr. Dye all medical and/or surgical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the above named doctor to release any and all information necessary to secure the payment of benefits.
I also understand that the above doctor reserved the right to charge for appointments cancelled or broken without 24 hours advanced notice.

_____

_____

Signature of Patient or Guarantor Date

Medical History:

1. Primary Complaint:

   _____

2. Date of Onset/Injury _____

   How did the injury occur?

   _____

3. What medical conditions have you had or currently have? _____

_____

_____

_____

_____

Are you currently under treatment for any of the above mentioned? YES NO

4. Are you currently taking any medication? YES NO

If yes, please list the names of the medications: _____

_____

_____

_____

5. Do you have any allergies (Yes or No)____ If yes, please list:_____

   _____

6. Do you have a cardiac pacemaker? (Yes or No)____

7. What surgeries have you had?

_____

_____

_____

8. Have you had any fractures or dislocations? YES NO
If yes, please list what area of the body and the date(s) of occurrence_____
_____
____

9. Do you have any bleeding problems? YES NO

10. Do you know of any medical disease(s) that run in your family? YES NO
If yes, please list
_____
_____
_____

Information about current problem:

Is an accident the cause of your present problem? YES NO
If yes, please explain
_____

What part of the body is injured?
_____

Was this a sports related injury? YES NO What sport? _____

Briefly describe how injury occurred:
_____
_____
_____

Have you seen another medical provider for this problem? YES NO
If so, who did you see
_____

Were any diagnostic tests done? YES NO what test?
_____

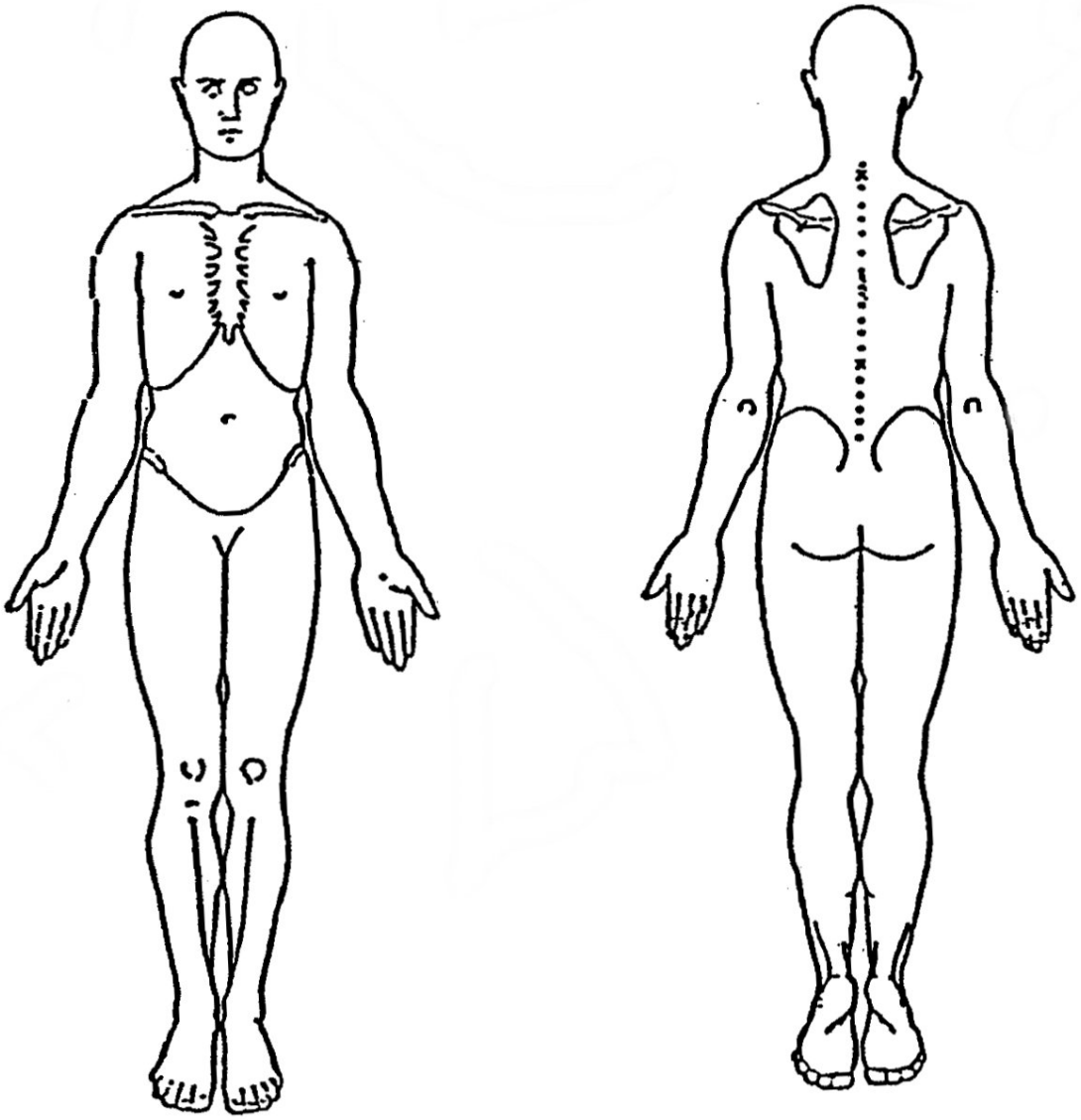
Have you had any prior surgeries to this area? YES NO

Please be sure to fill out this form as accurately as possible. Use no other symbols except those indicated. Mark the areas where you feel the described sensation. Use the appropriate symbol. Be sure to include radiation of pain to the affected areas.

Numbness ***
Pins & Needles **ooo**
Burning pain **xxx**
Stabbing pain ///
Aching pain **###**

Pain Scale: Please rate intensity of pain below

0	10
No pain	I need to go to the emergency room!



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY ACT

I understand that I have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing the consent.

The right to object to the use of my health information for directory purposes.

The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____

Patient signature Date