NewportCare®
MEDICAL GROUP
NEWPORT BEACH - ORANGE
COSTA MESA - LONG BEACH
MISSION VIEJO - RIVERSIDE

PATIENT INFORMATION FOR MEDICAL RECORDS

Today's Date _____

Patient Name _____

Birth Date _____ Age _____ Sex _____ Social Security No. _____

Address _____ City _____

State _____ Zip Code _____ Telephone No. _____

Occupation _____ Driver's License No. _____

Employer-Name _____ Employer Telephone No. _____

Employer Address _____

☐ Married ☐ Single ☐ Divorced ☐ Widow

EMAIL ADDRESS: _____

Spouse/or Responsible Parent _____

Birth Date _____ Age _____ Sex _____ Social Security No. _____

Address _____ Telephone No. _____

Occupation _____ Driver's License No. _____

Employer-Name _____ Employer Telephone No. _____

Employer Address _____

Emergency Contact(Other than husband or wife) person not living with you

Name _____ Relationship _____

Address _____ Telephone No. _____

- Please Complete if patient is under 21 years of age or a student

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Father's Employer _____ Mother's Employer _____

Address _____ Address _____

Medical Insurance Information

Primary Insurance Subscriber _____ Secondary Insurance Subscriber _____

Insurance Co. _____ Insurance Co. _____

Identification No. _____ Identification No. _____

Group No. _____ Group No. _____

Phone: 949 / 491 - 9991 FAX: 949 / 612 - 9795
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PATIENT HISTORY
FOR ORTHOPAEDICS

Patient Name: _____
Family Dr: _____ Address: _____ Phone: _____ Fax: _____
Chief Complaint: _____

If your condition related to an accident or injury? ☐ Yes ☐ No
Is this accident/injury related to : ☐ Auto Job Other: _____
Date of accident/injury: _____ Are you right or left hand dominate? ☐ Right ☐ Left
Injection: ☐ Yes ☐ No Occupation: _____ Hobby: _____
Have you had: Physical Therapy ☐ Yes ☐ No Use of assisted devices: _____
Have you had a: ☐ CT Scan ☐ MRI ☐ Xrays Other: _____

Past/Current Medical History:
☐ None ☐ Asthma ☐ Cancer ☐ Heart Disease ☐ Hear Failure
☐ Lung Disease ☐ Stroke ☐ GERD/Heartburn ☐ Hypertension ☐ Seizure
☐ Diabetes Other: _____

Past Surgical History: ☐ None Other: _____
Family History: ☐ Non contributory Other: _____
Social History:
☐ None ☐ Smoker: _____ x packs/days x yrs Recreational drug use: _____
☐ Alcohol ☐ Daily ☐ Weekly ☐ Monthly ☐ Rare

Review of Systems: All systems negative except as noted below
☐ General: ☐ Fatigue ☐ Unexpected Weight Loss
☐ Eye: ☐ Blurred vision ☐ Other: _____
☐ ENT ☐ Sore Throat ☐ Nasal Drainage/.Congestion Other: _____
☐ Pulmonary ☐ Cough ☐ Sputum Other: _____
☐ Cardiovascular ☐ Chest Pain ☐ Shortness of breath Other: _____
☐ GI ☐ Abdominal Pain ☐ Nausea/vomiting Incontinence Other: _____
☐ Skin ☐ Skin Rash ☐ Other: _____
☐ Genito-Urinary: ☐ Problems Urinating ☐ Abnormal discharge ☐ Incontinence Other: _____
☐ Psych: ☐ Depression ☐ Anxiety Other: _____
☐ Hematology: ☐ Bruising ☐ Other: _____
☐ Endocrine: ☐ Temperature Intolerance Other: _____
☐ Immune System: ☐ Choking Status Post Environmental Exposure Other: _____

Please list all current medications:

Please list all allergies:

Pharmacy Contact Info:

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PATIENT HISTORY
FOR ORTHOPAEDICS

Dr. Cheung New Patient General Questionaire: Date _____

Occupation: _____

Name _____ Age: _____

1. What body part is being evaluated? _____

2. How long have you had pain in that area? _____ months _____ Years

3. Was there an injury? ☐ No ☐ Yes: Description (include date of injury)

_____

_____

4. Were you seen in the Emergency room? ☐ No ☐ Yes:

Location: _____

5. Previous treatments given: ☐ Injections ☐ Narcotics ☐ Tylenol ☐ Surgery

☐ Anti-inflammatory Medication ☐ Cast ☐ Crutches ☐ Splints or Braces ☐ Physical therapy

6. Does pain radiate? ☐ No ☐ Yes: Where does it radiate?

_____

7. Type of pain: ☐ Sharp ☐ Dull/aching ☐ Tingling/Electric ☐ Burning ☐ Throbbing

8. Severity of pain from 0-10 scale (0 none, 10 maximum): _____

9. Degree of disability: ☐ None ☐ Slight/Occasional ☐ Mild with no effects on activities

☐ Moderate but tolerable ☐ Marked with serious limitations ☐ Totally disabling

10. Any prior injuries to affected area ? ☐ No ☐ Yes: (describe) _____

11. Aggravating factors: _____

12. Relieving factors: _____

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CONSENT FORM

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment. I authorize Newport Care providers and such physicians, associates, assistants, and other personnel or the hospital or medical facility chosen by him or her to perform the practice of medicine with the intention to improve my general well-being as discussed with me. At the time of treatment, I understand I can authorize any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the recommended procedure.

GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described to me in discussion with my provider. These risks include, yet are not limited to, the risk of bleeding, infection, pain, injury to neurovascular structures which control sensation, motor function and viability to the procedural region as well as anesthesia risks and death.

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this procedure or treatment as described to me in discussion with my provider.

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks as described to me in discussion with my provider.

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered. I also understand no treatment is always an option if I do not want to take the above discussed procedural/treatment risks.

SECOND OPINION: I understand I can be offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT: I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue, hardware or member in accordance with customary hospital or medical facility practice.

PHOTOGRAPHY: I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use.

NO GUARANTEES: I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

FINANCIAL POLICY: I understand that even if I have insurance, I may incur charges that are my responsibility. I understand that it is my responsibility to know my benefits and deductible information and whether or not the (PROCEDURE, DME PRODUCT, INJECTION) I am about to have is covered. If my deductible has not been met, or my insurance carrier denies this procedure, I understand that the financial responsibility is mine and that this office will bill me for services not covered or paid for by my insurance. If you are insured with a plan we are NOT contracted with, you are required to pay for the visits in full, at the time of service.

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read this form thoroughly.

DATE:_____ PRINT PATIENT NAME:_____

SIGNATURE:_____

(Patient, Parent, or Legal Guardian)

NewportCare® Medical Group

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

□ **Appointments (make, change, cancel)**

□ **Treatment Information**

I, _____, give permission to discuss the above indicated information with the following people:

Name	Relationship	Phone Number
1.		
2.		
3.		
4.		

Patient Name (please print) **Date**

Patient Signature

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: _____
Print Patient's Name

NewportCare Medical Group
Print or Stamp Name of Physician, Medical Group, or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.