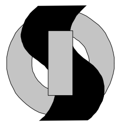


Orthopaedic Specialty Institute
Medical Group of Orange County

__________________________, your appointment with Dr. Shepard is scheduled for:

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

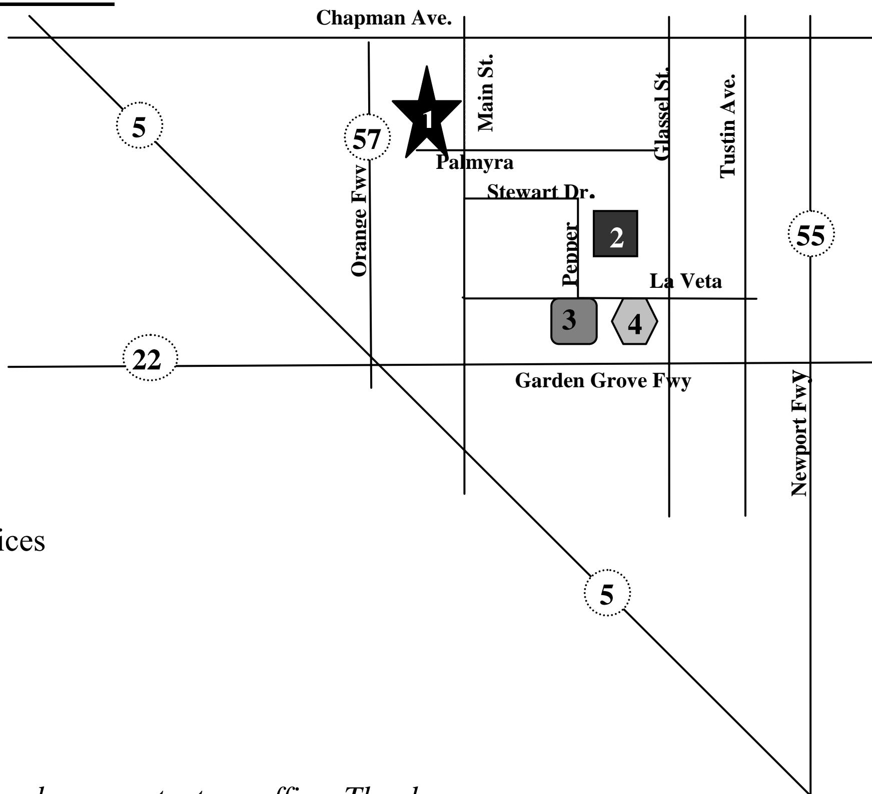
DATE: ___________________________________ TIME: ______________

****Kindly give 24 hour notice of cancellation****

Please remember to bring:

- ✓ Any forms sent by my office to be filled out at home
- ✓ **Insurance Cards and/or Claim Forms**
- ✓ *****X-rays, MRI films, CT Scan, etc. relating to injury***- otherwise appt will be rescheduled.**
- ✓ **For female shoulder patients: please bring or wear a tank, halter, or bathing suit top**
- ✓ **For hip, knee and ankle patients: please bring or wear a pair of shorts**
- ✓ **Patients with injuries to the back or neck will be evaluated in a gown**

Orthopaedic Specialty Institute
Michael Shepard, M.D.
280 S. Main Street, Suite 200
Orange, CA 92868
(714) 937-2148



St. Joseph Hospital

St. Joseph Pavilion

Orange Surgical Services

If you need further assistance, please contact my office. Thank you.

Orthopaedic Specialty Institute
Medical Group of Orange County

Orthopaedic Specialty Institute
280 South Main St.
Orange, CA 92868
(714) 634-4567

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP			REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)					SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP					SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS				CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE		
RELATIONSHIP TO PATIENT								

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits, and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A Photostat of this authorization is accepted with the same authority as original.

This agreement will remain valid from this day forward to include all future services relating to the above patient. rev 3/08

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________

Michael F. Shepard, M.D.
Orthopaedic Specialty Institute

MEDICAL HISTORY DATE: ________________

NOTE: PLEASE TRY TO ANSWER EVERY QUESTION TO THE BEST OF YOUR ABILITY.
EVERYTHING IS KEPT CONFIDENTIAL.

PATIENT NAME: ________________________________ DATE OF BIRTH: __________

CHIEF COMPLAINT____
PLEASE DESCRIBE THE RECENT EVENTS OF THIS CURRENT ORTHOPAEDIC PROBLEM. HOW LONG HAS IT BEEN A PROBLEM? WHAT MAKES IS WORSE? WHAT MAKES IT BETTER?
____
____
____
____

ONSET DATE ________________

DO YOU WEAR GLASSES/CONTACTS/NONE (PLEASE CIRCLE)

NAME OF THE PHYSICIAN WHO REFERRED YOU TO US ________________________________
DRUG ALLERGIES ____

CURRENT MEDICATIONS: PLEASE LIST ASLL CURRENT MEDICATIONS. IF UNSURE, CALL OR MAIL ACCURATE LIST AS SOON AS POSSIBLE.

MEDICATION DOSE FREQUENCY

1. ____
2. ____
3. ____
4. ____
5. ____

PAST SURGERIES: LIST PAST SURGERIES IN CHRONOLOGICAL ORDER:

TYPE OF SURGERY YEAR

1. ____
2. ____
3. ____
4. ____
5. ____

Michael F. Shepard, M.D.
Orthopaedic Specialty Institute

PATIENT NAME ______________________________ **DATE**__________

FAMILY MEDICAL HISTORY: List medical illness affecting your immediate family

	Disease	Family Member		Disease	Family Member
1.			4.		
2.			5.		
3.			6.		

__________ Height __________ Weight

SOCIAL HISTORY: Check and fill in blanks

______ Married ______ Single ______ Divorced ______ Live Alone ______ # Children ______Pets

______ Alcohol ______ Occasional ______ Daily ______ Heavy

______ Tobacco ______Years Used ______Packs per day ______Drugs

GENERAL HISTORY: Please fill out and check all that apply.

General

_____ 1.Weight Change
_____ 2.Fever or Chills
_____ 3. Night Sweats
_____ 4.Urinary Frequency
_____ 5.Bleeding
_____ 6.Lumps or Masses
_____ 7.Dizziness or Fainting
_____ 8.Itching or Rash
_____ 9.Diabetes Mellitus
_____ 10.Thyroid Problem
_____ 11.Cancer

Gastrointestinal

_____ 1. Dysphagia (difficulty swallowing)
_____ 2. Nausea & Vomiting
_____ 3. Jaundice
_____ 4. Hepatitis

Genitourinary

_____ 1. Urinary Infections
_____ 2. Incontinence
_____ 3. Venereal Disease
_____ 4. Menopause

Cardiovascular

_____ 1. Heart dx/Pain
_____ 2. Hypertension
_____ 3. Mitral Valve Prolapse
_____ 4. Thrombophlebitis

Neurological

_____ 1. Seizures
_____ 2. Paralysis
_____ 3. Numbness
_____ 4. Weakness

Ear-Nose-Throat-Eye

_____ 1. Visual Change
_____ 2. Hearing Change
_____ 3. Tinnitus
_____ 4. Dentures
_____ 5. Bleeding Gums
_____ 6. Hoarseness

Respiratory

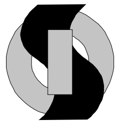
_____ 1. Cough/Sputum
_____ 2. Rheumatic Fever
_____ 3. Tuberculosis
_____ 4. Pleurisy/Pneumonia
_____ 5. Shortness of Breath
_____ 6. Asthma

Musculoskeletal

_____ 1. Backache
_____ 2. Joint Pain
_____ 3. Joint Swelling

Breast

_____ 1. Lumps, Pain,
Nipple Discharge



Orthopaedic Specialty Institute
Medical Group of Orange County

Accident/Injury Information Form

Name: ________________________ Doctor: _________________

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? ___________________________
____
____

Where did your accident/injury occur? __________________________
____
____

How did your accident/injury occur? ____________________________
____
____

Signature: ______________________ Date: ______________________

Thank you for your assistance.

280 S. Main Street - Suite 200 - Orange, CA 92868 – Tel. (714) 634-4567

Acknowledgement of Receipt of Notice of Privacy Practices

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ______________________________ Date: ________________________

Print Name: __________________________ Telephone: ____________________

If not signed by the patient, please indicate:

Relationship:

- □ parent or guardian of minor patient
- □ guardian or conservator of an incompetent patient
- □ beneficiary or personal representative of deceased patient

Name of Patient: ____

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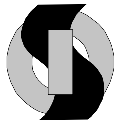

Orthopaedic Specialty Institute
Medical Group of Orange County

Blue Cross/Anthem Patient,

Thank you for choosing the Orthopaedic Specialty Institute. Please be advised that effective June 25th, 2007, the doctors of OSI decided to leave Blue Cross of California/Anthem. We are still able and happy to provide care for you and your family. **Please check with Blue Cross/Anthem to determine if your policy has out of network benefits as there are various Blue Cross/Anthem plans**. If you do not have this type of coverage, please contact our office prior to your appointment to discuss payment arrangements.

Once services are rendered and we submit your claim to Blue Cross/Anthem, they may mail the payment to you, the subscriber, rather than directly to OSI. This check represents the Blue Cross/Anthem portion of reimbursement for medical services provided and therefore is owed to OSI. If this occurs, we ask that you sign the back of the check and write "Pay to the order of OSI" or write a personal check for the same amount and mail to our office to be applied to your outstanding balance. Please be aware that if you deposit or cash the check, you will still be responsible for the full balance of your account.

Please be advised that you are responsible for any charges incurred regardless of insurance coverage.

By signing this letter, you indicate that you understand the above information and agree to forward any payments from Blue Cross/Anthem to OSI for any services rendered at our facility.

______________________________ _______________
Patient Signature Date

____
Patient Name (please print)