William W. Winternitz Jr., M.D., Inc.
Pomerado Orthopedic Specialists
Orthopedic Surgery and Joint Replacement
Fellowship Trained, Board Certified in Sports Medicine

12630 Monte Vista Road, Suite 105 Poway, Ca 92064
(858)-487-6440 Fax: (858) 487-7281
www.pomeradoortho.com

PATIENT REGISTRATION INFORMATION FOR MINOR CHILD
CHILD'S INFORMATION

NAME: ______________________________ AGE ________ DATE OF BIRTH ________________

ADDRESS ______________________________ CITY ________________ STATE ______ ZIP ________

Home Phone ( ) ______________________________

Male [ ] Female [ ]

PRIMARY DOCTOR ______________________________ REFERRED BY: ______________________________

RESPONSIBLE PARTIES- CO-PAYMENTS MUST BE PAID PRIOR TO EACH VISIT. THE PARENT ACCOMPANYING THE PATIENT WILL BE RESPONSIBLE FOR PAYEMENT. THANK YOU

MOTHER'S NAME ______________________________ DATE OF BIRTH ________________

ADDRESS ______________________________ CITY ________________ STATE ________ ZIP ________

SS# ________________ HOME PHONE ______________________ CELL PHONE ______________________

FATHER'S NAME ______________________________ DATE OF BIRTH ________________

ADDRESS ______________________________ CITY ________________ STATE ________ ZIP ________

SS# ________________ HOME PHONE ______________________ CELL PHONE ______________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ______________________________

POLICY HOLDER'S NAME ______________________________ ID # ______________________________

SECONDARY INSURANCE COMPANY ______________________________

POLICY HOLDER'S NAME ______________________________ ID # ______________________________

CONSENT FOR TREATMENT/RELEASE OF INFORMATION

I GRANT CONSENT TO DR. WINTERNITZ TO ADMINISTER MEDICAL TREATMENT AND PERFORM MEDICAL PROCEDURES AS DEEMED NECESSARY. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURER, OR THE INSURER'S AGENTS TO PROCESS MY PAYMENT FOR SERVICES. TO THE BEST OF MY KNOWLEDGE, ALL THE INFORMATION ABOVE IS TRUE AND CORRECT. ASSIGNMENT OF BENEFITS: I HEREBY ASSIGN ALL BENEFITS PAYABLE BY MY INSURANCE COMPANY TO WILLIAM W. WINTERNITZ JR., M.D.

PARENT OR GUARDIAN SIGNATURE ______________________________ **DATE** ________________

DATE ____________________

Name: ____Age________DOB____________Height______Weight______

Side of Injury: Right_______ Left_______ **Referred By**: ____

Dominant Hand R L

Reason For Visit/What Bothers You Now? ____

____

____

Date of Injury or Duration of Symptoms: ____

How did The Injury Occur? ____

____

What Makes Your Pain Worse? ____

____

What Makes Your Pain Better? ____

____

Pain Scale: 1 2 3 4 5 6 7 8 9 10

Least Moderate Severe

What Treatment Have You Had For Your Injury? ____

____

Who Were Your Treating Doctors? ____

____

Any prior injury to the affected area? Yes No

What occurred? ____

____ When? ____________________________

Any Prior Studies Performed? X-rays MRI CT scan Bone Scan EMG

When? ______________________________Which facility? ____

Name: ______________________________ **Date:** ______________

MEDICAL HISTORY:

___Check here if all negative

___High Blood Pressure
___Diabetes
___Heart Disease
___Heart Attack
___Heart Arrhythmia, chest pain
___Asthma
___Emphysema
___Ulcer Disease, Hiatal Hernia
___Hepatitis
___Fibromyalgia
___Bleeding Disorder
___Seizures
___Thyroid Problems
___Osteoporosis
___Cancer______________
___Phlebitis/blood clots
___Stroke
___Kidney Stones
___Prostate Problems
___Headaches, Migraines
___Sleep Apnea
___Muscular Dystrophy
___HIV

Are you pregnant? Y or N

SURGICAL HISTORY:

___Check here none

YEAR	PROCEDURE	YEAR	PROCEDURE
______	______________________	______	______________________
______	______________________	______	______________________

HOSPITALIZATIONS: ____

CURRENT MEDICATIONS:

____Check here if none

NAME OF DRUG	DOSAGE (mg)	TIMES PER DAY
______________________	__________	______________
______________________	__________	______________
______________________	__________	______________
______________________	__________	______________
______________________	__________	______________
______________________	__________	______________

Name: ______________________________ **Date:** ________________

ALLERGIES:

___Check here if none

Foods____________________________ ___Dust ___Pollen ___Cats ___Dogs

___Latex ___Iodine ___Adhesive Tape ___Nickel

___Metal

Medicines: ___Penicillin ___Sulfa other: ____

SOCIAL HISTORY:

Occupation: ____full time _____ part time ____

Education _______grade _____high school ____college ____post graduate

_____Single ____married ___committed ___divorced other____________________________

CHILDREN ____none ____number

TOBACCO ____never____stopped ______year currently smoking____packs per day times ____years

ALCOHOL ___none ____few per month ____1/week _____few per week ____daily

DRUG USE ___none other____

EXERCISE ___none ___1/month ___few times per week ___daily

ADAPTIVE DEVICES:

___check here if none

___foot support / orthotic ___ankle brace / AFO ___corset ___spine brace other__________________

___crutches ___ walker ___ wheel chair other______________________

FAMILY HISTORY:

Mother ___alive ___deceased cause____

Father ___alive ___deceased cause____

Number of sibling's _____

Family Medical Problems ___diabetes ___heart disease ___cancer ___spine problems

other____

Name: ______________________________ **Date:** ____________________

REVIEW OF SYSTEMS:

How would you rate your health: ___excellent ___good ___ fair ___poor

Do you have any of the following symptoms? Circle If (Yes).

___NONE	**Constitutional:**	fever weight loss tiredness
___NONE	**Eyes:**	glasses blurred vision double vision
___NONE	**ENT:**	deafness sinus infection ringing hoarseness dizziness difficulty swallowing
___NONE	**Heart:**	chest pain irregular heart beat pounding in chest
___NONE	**Lungs:**	shortness of breath wheezing cough cough up blood
___NONE	**Abdomen:**	loss of appetite diarrhea constipation abdominal pain Blood in stool black bowel movements
___NONE	**Urinary:**	burning loss of urine difficulty voiding infections blood in urine
___NONE	**Musculoskeletal:**	sprains swelling arthritis stiffness
___NONE	**Skin/Breast:**	rash skin ulcers sores lumps birthmarks masses
___NONE	**Neurologic:**	balance problems memory problems
___NONE	**Behavioral:**	depression anxiety sleep disturbance hallucinations claustrophobia
___NONE	**Endocrine:**	hair growth/loss crave fluids/food hyperactive sleep all the time

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PATIENT CONSENT/ ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by **William W. Winternitz Jr., M.D**., our staff, and our business associates for treatment, payment and health care operations. For more detailed descriptions and of use and disclosure for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at **(858) 487-6440** and requesting a revised Notice. We will also post any revised Notice in the office.

You have the right to request that we restrict our uses and disclosures of you protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY, I HAVE BEEN OFFERED A COPY OF THE MEDICAL MATERIALS FACT SHEET REVISED 2004.

NAME: ______________________________ **DATE:** ______________

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT/ ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.

ALL FORMS ARE FOR EDUCATIONAL USE ONLY AND DO NOT CONSTITUTE LEGAL ADVICE. ALL FORMS ARE SUBJECT TO CHANGES IN THE FEDERAL LAW AND APPLICABLE STATE LAWS. SEEK LEGAL ADVICE BEFORE USE.

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PATIENT ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I, the patient or legal guardian, understand that it is my responsibility to provide a copy of my health insurance card to William W. Winternitz Jr., MD medical practice to facilitate claims processing. If I am unable to provide this information at the time of the office visit, I understand that my appointment will be my financial responsibility until such information is provided, and that I will be required to pay the cost of the office visit at the time of the office visit.

I further understand that it is my responsibility to know if my provider is contracted under my health plan and if it is not, I agree to pay in full for any charges incurred as result of care that I received.

If an insurance card is given, and it is subsequently determined that I am "not eligible" under my insurance member provisions and/or that any specific procedures are not covered, I agree that the financial responsibility for services rendered is mine.

Sign: ____ Date: ____________________