GEORGE W. BALFOUR, M.D.
ELI T. ZIV, M.D.
JENNIEFER KHO, M.D.

PATIENT INFORMATION

Today's Date________________ **Date of Birth_____/_____/_____**

Last Name _____________________ First Name _____________________ M.I. _____

Address _______________________ City __________________ State ____ Zip ______

Email _____________________________

Home Phone ______________ Work Phone _______________ Cell _______________

Driver's License # ___________________ Social Security _______________________

Emergency Contact Name _____________________ Phone # ____________________

Employer/School ____

Spouse/Parent's Name ____

Subscriber Policy Information:
Or attach a copy of insurance card(s) front and back

Insurance Name____
Primary policy holder relationship to patient __Self __Spouse __ Parent/Guardian
Last Name ___________________ First Name _________________
Address____________________ City __________________ State _____ Zip _______
Phone ________________ Social Security _____________ Date of Birth __________

Secondary Policy Information

Insurance Name____
Primary policy holder relationship to patient __Self __Spouse __ Parent/Guardian
Last Name ___________________ First Name _________________
Address____________________ City __________________ State _____ Zip _______
Phone ________________ Social Security _____________ Date of Birth __________

Guarantor (*The Guarantor is the person responsible for co-pays, deductibles and services not covered by insurance when applicable and only if it's someone NOT listed above.*)
Last Name _________________________ First name __________________________
Address ______________________City ____________________ State ____ Zip _____
Home Phone _______________________________ Date of Birth _________________

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NEW PATIENT QUESTIONNAIRE

Name: Mr./Mrs./Ms./Dr. ________________________________ Age: ________

Preferred Name: __________________________

Primary Doctor: ____________________ Who referred you? _________________

Occupation: _____________________________ Dominant Hand: Right / Left

What problem/body part are you being seen for? __________________________
____ Right / Left / Both

Did this problem: ___ Start gradually ___Start suddenly ___ An injury

If not an injury, when did it start/how long has it been a problem? _______________
____

If an injury, how did it happen? ____
____

Do you have: ____ Pain ____ Swelling or bump ____ Numbness
Other symptoms: ____

If you have pain, rate it from 1-10: ____/10

If you have pain, is it worse:
____ With use ____ With gripping ____ At rest ____ Daytime ____ At night

If you have pain, how often? ______________________________________

If having numbness, do fingers fall asleep? ___Yes ___ No
Is it worse:
____ With use ____ At rest ____ Driving a car ____ Daytime ____ Nighttime

If you have a bump or swelling, is it:
____Getting bigger ____Getting smaller ____ Not changing

Any treatment so far for this problem? ____Yes ____No
If yes, what: ____

Any medication taken for this problem? ____Yes ____ No
If yes, what / how long: ____

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Past Medical History (list any of your current or former health conditions):
____
____
____

List any surgeries or procedures in the past:
____
____
____

Orthopaedic History (especially any prior problems with the body part being seen for today):
____

Have you seen Dr. Kho before? ____ Yes ____ No _____ Date

Current medications you are taking: ____
____
____

Allergies to medication: ____
____

Do you any history of the following (please circle):

Heartburn	High blood pressure	Asthma	Chest pain
Ulcer	Bleeding problems	COPD	Arrhythmia
Hypothyroid	Shortness of breath	Cancer	Hepatitis B/C
Diabetes	Emotional problems	HIV	Seizures
Arthritis	Kidney disease	Gout	Chronic pain

Any family history of orthopaedic or anesthesia problems?

___Yes ___ No If yes, then what? _____________________________________

Do you smoke? ____Yes ____ No
Drink alcohol? ____Yes ____No ____# Drinks/week

Any current/prior issues with drug/alcohol abuse? ___ Yes ___ No
Current/prior issues with prescription drug abuse? ___Yes ___ No

Any other concerns the doctor should know about? ___________________________

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Office Policy

(Please read each policy and write your initials and today's date.)

Release of X-Rays: Federal and State Laws require that this office keep all X-rays performed in our office as part of the patient's medical records. We do not release original X-rays. If you would like a copy of your X-ray(s), we will be happy to do so at a cost of $15 per CD.

Please note that our office may require a minimum of one week to process your films. This cannot be done same day.

________ ________
Initials **Date**

Appointments: We request that every patient call and make an appointment before coming in to the office. In case of an emergency, please call first before coming in. We appreciate a 24-hour notice for canceling follow-ups, and at least one hour notice for canceling an appointment due to illness or other problems. A $25 fee will be billed for missed appointments without notifications: missed appointments without proper notice would mean that future appointments will no longer be available.

________ ________
Initials **Date**

Disability Forms: There is a $20 fee for our office to complete disability forms (excluding FMLA) and more extensive forms may require additional charges.

________ ________
Initials **Date**

PPO Patients: Over the last few years the majority of PPO insurance plans have high out of pocket deductibles, ranging from several hundred to several thousand dollars. With such a plan, the insurance does not pay anything toward your care until the deductible has been met. If this is the case, we may ask you to pay the estimated total cost of the office visit at the time of your visit.

________ ________
Initials **Date**

HMO Patients: (Healthcare Partners, Facey, Motion Picture, Regal, Lakeside, Providence, Preferred IPA, Blue Shield Promise):
You must have authorization/a referral from your Primary Care Physician before we can see you. You are responsible for obtaining this authorization and for any charges that are excluded by your insurance. In addition: Your co-pay must be paid at the time of your visit. Also note that HMO plans do not cover items like braces (DME) and may severely limit where you can go for services like physical therapy, X-rays and surgery centers.

________ ________
Initials **Date**

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HIPAA

Use and Disclosure of your protected Health Information

Your protected health information will be used by Dr. Kho or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health may be used or disclosed. You may request and receive a copy of the notice any time.

You may request a restriction on the use or disclosure of your protected health information. Dr. Kho may or may not agree to restrict the use or disclosure of your protected health information. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right Change Privacy Practices

Dr. Kho (Valley Hand & Orthopaedics) reserves the right to modify practices outlined in the notice.

Disclosure to Specified Individuals

I give my permission for my protected health information to be disclosed for the purposes of communication results, findings and care decision to my family members and others listed below.

Name:______________________________________
Name:______________________________________

I have reviewed this consent form and give my permission to Dr. Kho to use and disclose my health information in accordance with it.

________ ________
Initials **Date**

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Authorization and Assignment Form

By signing this form you are voluntarily giving your general consent for Dr. Kho to examine, evaluate and treat your orthopaedic condition. This also covers X-rays, ultrasound, injections and minor procedures. If it is determined that you will require a more involved procedure, you will be asked to sign a more specific informed consent.

______________________________ ___________________
Patient Signature **Date**

______________________________ ___________________
Parent/Legal Guardian Signature **Date**
(If applicable)

I hereby authorize Dr. Kho (Valley Hand & Orthopaedics), to provide my insurance company and/or my employer the information they require to complete my claim.

I also authorize my insurance company to pay Dr. Kho directly for my surgical/medical benefits. I understand that I am financially responsible for the charges not covered by this authorization.

____ _______________
Patient or Subscriber Signature **Date**

Welcome to my practice! Thank you for your understanding and cooperation. I look forward to providing you with excellent care.

Jenniefer Kho, MD