Patient Registration Form

GORDON C. LUNDY, M.D., A.P.C. - ORTHOPAEDIC SURGERY
2100 WEBSTER ST., SUITE 117 - SAN FRANCISCO, CA 94115
(415) 923-3015 FAX (415) 923-3501

Demographic Information

Last Name: ______________________ First Name: ______________ Middle: ______

Home Address: ______________________________ City: ______________

State: _____ Zip: _________ Home Phone (_____) ___________ Cell (_____) __________

Social Security #: ________-________-________ Date of Birth: ______________

Employer: ______________________________ Occupation: ______________

Address: ______________________________ City: ______________

State: _____ Zip: _________ Work Phone (_____) ___________ Extension __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow Email: ______________

Name of Spouse / Partner: ______________________________

Who is your Primary Care Physician?

Name: ______________________________ Phone (_____) __________

Address: ____________________ City: __________ State: _____ Zip: ______

Emergency Contact

Name: ______________________________ Phone (_____) __________

Address: ____________________ City: __________ State: _____ Zip: ______

Relationship: ______________________________

Insurance Information

Name of Primary Insurance Company: ______________________________

Name of Secondary Insurance Company: ______________________________

Name of Tertiary Insurance Company: ______________________________

About the Policy Holder:

Full Name: ____________________ Date of Birth: ______________

Address: ____________________ City: __________ State: _____ Zip: ______

Social Security #: ______________ Relationship to the Patient: ______________

Gender: Male _______ Female _______

For patients under the age of 18 years old, the undersigned Parent/Guardian authorizes treatment and agrees that the policy holder will be named as the account guarantor unless noted otherwise in writing.

Signature: ____________________ Print Name: ______________

Relationship: ____________________ Today's Date: ______________

Register for our

Online Patient Portal

A service provided by Brown & Toland Physicians

FIRST NAME LAST NAME

DATE OF BIRTH (DOB) E-MAIL ADDRESS

After turning in this card, you will receive an e-mail from our office.
Click the link to continue the registration process.

For internal use. MRN # ________________

Use the new patient portal to manage your health or the health of someone in your care, share information with a member of your healthcare team and make informed decisions about your healthcare. You will be able to use this portal to:

- Communicate securely with your physician and office staff
- Request an appointment
- View lab results
- Request a prescription
- Access your medical history

Patient Medical History

Last Name: ______________________ First Name: ______________ Middle: ______

Date of Birth: __________ ____ Age: __________ Sex: ______Marital Status: ________

Occupation: ________________ **Primary Care Physician:** ________________

Height: ________ Weight: ________ Weight one year ago: ________ Children: ______

I am: □ Left Handed □ Right Handed Who may we thank for your referral? ____________

Are we seeing you in relation to an injury/accident? □ Yes □ No If yes: Date of Injury? __________

□ Automobile Accident □ Work-Related Injury □ Other ______________________

Are you on Disability? □ Yes □ No If yes: Last Date of Work? __________

Current Medical problems:

□ Diabetes
□ Ulcer
□ Arthritis
□ Hepatitis
□ Chest Pain
□ Asthma
□ High Blood Pressure
□ High Cholesterol
□ Bowel Disorder
□ Emphysema
□ Heart Failure
□ Thyroid Disease
□ Cancer / Type ________
□ Kidney Disease
□ Prostate Disease
□ Heart Murmur
□ HIV
□ Other: __________

1) What medications do you take routinely? (Include dosage and frequency) __________

____

____

2) Allergy to Medication: ______________________________

3) Are you currently using intravenous or recreational drugs? (Include type and amount per day)

____

4) Past Surgeries (Include type and dates): ______________________

____

Do you smoke now? □ Yes □ No # of packs per day? _____ How many years? _____

If you quit smoking, how long ago? ________ # of packs per day? _____ How many years? _____

Do you drink alcohol? □ Yes □ No How may ounces per day? _____
(One 12 oz. beer or one glass of wine = 1 oz. of hard liquor)

Diet: □ High in fat / Cholesterol □ Moderate □ Low □ Vegetarian

How many times per week do you exercise? ________ What type? ______________

Father: □ Alive □ Deceased Age and cause of death: ______________
Mother: □ Alive □ Deceased Age and cause of death: ______________
Sibling: □ Alive □ Deceased Age and cause of death: ______________
Sibling: □ Alive □ Deceased Age and cause of death: ______________

Are there any diseases that run in your family? ______________________

Date of last menstrual period: ______________ Age at Menopause: ______________

Review of Systems

Last Name: ______________________ First Name: ____________________ Date of Birth: ________

Please check any illness, symptoms or problems that you have had in the last month:

Constitutional
- ☐ Blood Pressure
- ☐ Respiration
- ☐ Fever/sweats
- ☐ Fatigue
- ☐ Loss of appetite / weight change

Eyes
- ☐ Eye Disease of injury
- ☐ Eye glasses / contact lenses
- ☐ Blurred / double vision
- ☐ Glaucoma

Ears / nose / mouth / throat
- ☐ Hearing loss
- ☐ Hearing noises in your ear
- ☐ Earaches and drainage
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Snoring
- ☐ Voice changes
- ☐ Problems with thyroid

Musculoskeletal
- ☐ Joint pain / stiffness
- ☐ Muscle pain / cramps / weakness
- ☐ Back pain

Skin
- ☐ Rashes
- ☐ Lesions
- ☐ Ulcers

Cardiovascular
- ☐ Chest pain / angina
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Swelling of feet, ankles or hands
- ☐ Murmur

Respiratory
- ☐ Cough
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Problems with bowel movements
- ☐ Nausea / vomiting
- ☐ Rectal bleeding / blood in stool
- ☐ Abdominal pain / heartburn

Genitourinary
- ☐ Flank pain
- ☐ Problems with urination
- ☐ Blood in urine
- ☐ Kidney stone

Neurological
- ☐ Headaches
- ☐ Numbness / tingling sensation
- ☐ Tremors
- ☐ Head injury

Hematologic / lymphatic
- ☐ Slow to heal after cuts
- ☐ Tendency to bleed / bruise
- ☐ Blood clots
- ☐ Past blood transfusion

Other Symptoms
- ☐ Memory loss / confusion
- ☐ Nervousness / Anxiety
- ☐ Depression
- ☐ Insomnia

Completed by: ______________________ Relationship: ______________ Today's Date: __________

Gordon C. Lundy, M.D., A.P.C.
Orthopaedic Surgery

Patient Disclosure

Dear Patient,

While under our care, you may be advised to undergo surgery/procedures for diagnosis or management of your condition. We are in partnership with California Pacific Medical Center and Presidio Surgery Center, where these procedures can be safely and effectively performed.

California Business and Professions Code Section 654.2 require that we disclose that we have financial interest in the Presidio Surgery Center.

You may choose to have your procedures or surgery at a site in which we do not have a financial interest. If you wish, we can recommend an alternative site.

Acknowledgement of Disclosure:

Signature: ______________________________ Date: ____________

Please send/fax back to office

Gordon C. Lundy, M.D., A.P.C.
Orthopaedic Surgery

Patient Consent

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment and healthcare operations. Protected health care information is individually identifiable information we create or receive, including information related to your physical and/or mental health that we use to provide healthcare services to you as well as obtain payments for services provided.

With this consent, Dr. Lundy may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including tests and laboratory results among others.

With this consent, Dr. Lundy may mail to my home or other alternative location any items that assist the practice in carrying out healthcare operations, such as patients statements as long as they are marked Personal and Confidential. In addition, I give Dr. Lundy permission to speak with the following family members, spouse, roommate, etc regarding billing issues, lab results, or any other information pertaining to my treatment and care.

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

If you do not sign this Consent Form, we have right to refuse you treatment unless we are required by law to treat you. You have the right to revoke this consent in writing except where we have already made disclosures in reliance to your prior consent. You may use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter with written request.

I have read and understand the policy as outlined above.

Signature of Patient/Legal Guardian: ______________________ Relationship: ______________________

Patient Name(print): ______________________ Date: ______________________

Gordon C. Lundy, M.D.
Orthopaedic Surgery

Office Policies

Dear Patient,

Thank you for your continued support of this practice. We would like to take this opportunity to inform you about our policies.

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and by notifying us at least 24 hours In advance if you are unable to do so. Patients who fail to arrive for their scheduled appointment or who cancel with less than 24 hours advanced notices will be charged a missed appointment fee of $50. This fee cannot be charged to your insurance carrier.

All office visit co-payments are expected at the time of service.

Please allocate at least 1½ hours towards your appointment. This is at times a difficult area to find parking, therefore remember to include enough time for this while planning your visit.

For all medication refills, please call your pharmacy directly. Please allow 24 hours turnaround time for prescription requests. Please note that we do not process these requests on Fridays.

If you have any billing questions, please contact our billing department between 8:00am and 4:30pm, Monday through Friday at (415)972-4500.

This practice charges $20 fee for all forms, applications and some letters that need to be completed by Dr. Lundy; there is a 1 week turnaround time this this service. Fee for completing forms cannot be charged to your insurance carrier.

We will bill your insurance companies as a courtesy; however, it is the patient's responsibility to pay for all charges not covered by their insurance, including but not limited to, co-payments, deductibles, co-insurance, and non-covered services.
The patient also agrees to complete all necessary paperwork in order for his/her claim to be paid by an insurance company and accepts full liability for all charges if payment is not made by the insurance company.

Finally, as a courtesy to staff and other patients, please refrain from using your cell phone while in the office.

Signature: Date:

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