Sanjum Samagh, M.D.

Advanced Arthroscopic Orthopaedic
Surgery & Sports Medicine

Patient Name: ______________________________
Date of Birth: _______________________________

Medical Form

Are You: [ ] Right Handed [ ] Left Handed **Height: _________ Weight: ________**

Date of injury or onset of problem: ______________________

OB/GYN for WOMEN: Are you pregnant now? [ ] Yes [ ] No

Is this work related: [ ] Yes or [ ] No **Is this case in litigation? [ ] Yes or [ ] No**

Orthopaedic Problem/Symptoms: [ ] Right or [ ] Left (Choose One)

____

____

Condition caused by: ____

Brief explanation of injury:

____

____

____

What treatment have you had thus far?

____

____

Patient or Authorized Representative Signature (Relationship):___________________________ Date: ____________

310 Santa Fe Drive Suite #112 Encinitas CA 92024
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Do you have any Allergies?

Please list any known drug, food, or environmental allergies below: **[ ] List attached**

Current Medications

List any medications you are taking, including over the counter and supplements: **[ ] List Attached**		
Medication	Dose	How Often?

PAST MEDICAL HISTORY		
Arthritis	No	Yes
Asthma	No	Yes
Cancer	No	Yes
Diabetes:[ ] Type 1 or [ ] Type 2	No	Yes
Emphysema	No	Yes
Heart Disease	No	Yes
Hepatitis	No	Yes
Hypertension	No	Yes
Kidney Disease	No	Yes
Osteoporosis	No	Yes
Peptic Ulcers	No	Yes
Stroke	No	Yes
Thyroid Problems	No	Yes

FAMILY MEDICAL HISTORY			**If yes, state who: maternal/paternal**
Arthritis	No	Yes	
Asthma	No	Yes	
Cancer	No	Yes	
Diabetes	No	Yes	
Emphysema	No	Yes	
Heart Disease	No	Yes	
Hepatitis	No	Yes	
Hypertension	No	Yes	
Kidney Disease	No	Yes	
Osteoporosis	No	Yes	
Peptic Ulcers	No	Yes	
Stroke	No	Yes	
Thyroid Problems	No	Yes	

Social History:

What is your smoking history?		**What is your Alcohol Intake?**	
Never smoked		I do not drink Alcohol	
Former smoke		I drink alcohol occasionally	
Currently smoke daily		I drink alcohol Heavily	
I currently smoke some days		Former alcohol drinker	

Which best describes your situation?

Living Alone [ ] **Living with Friends [ ]**

Living with Family [ ] **Other [ ]**

Past Surgical Procedures:

List any surgical procedures you've had and your approximate age at the time: **[ ] List attached**	
Procedure	**Age**

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Review of Systems

Constitutional		
Significant Weight Change	Yes	No
Fever/Chills	Yes	No
Fatigue	Yes	No
Feeling Tired or Poorly	Yes	No
Cardiovascular		
Chest pain	Yes	No
Rapid or Irregular Heartbeat (Palpitations)	Yes	No
Leg pain with Exercise (Leg Claudication)	Yes	No
Slow Heartrate	Yes	No
Leg Swelling	Yes	No
Respiratory		
Cough	Yes	No
Wheezing	Yes	No
Chest Tightness	Yes	No
Pain with Respiration	Yes	No
Shortness of Breath	Yes	No
Asthma	Yes	No
Gastrointestinal		
Abdominal pain	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Black Stool	Yes	No

Heme/Lymph		
Easy Bleeding	Yes	No
Easy Bruising	Yes	No
Swollen Glands	Yes	No
Neurological		
Convulsions	Yes	No
Confused/Disoriented	Yes	No
Fainting (Syncope)	Yes	No
Difficulty Walking	Yes	No
Weakness	Yes	No
Dizziness (Vertigo)	Yes	No
Musculoskeletal		
Leg pain	Yes	No
Localized joint stiffness	Yes	No
Localized joint pain	Yes	No
Soft Tissue Swelling	Yes	No
Joint Swelling	Yes	No
Muscle Aches (Myalgia's)	Yes	No

List any other medical conditions that you may have: ____________________

____

____

____

Primary Care Physician: ______________________________ Referring Physician ______________________________

Name of Pharmacy: ______________________________ Pharmacy Phone: ______________________________

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<u>HIPAA Authorization for use or disclosure of health information:</u>

I authorize <u>Sanjum Samagh, M.D.</u> To leave messages with medical information on Voicemail/Answering Machine/E-mail at: (Please check) (Please note that if you contact us in any form you did not check and request a response back via that same method you are then authorizing us to use that method at that time).

____ Home ______ Cell Phone ______ Work ______E-mail

Please check here if you authorize us to send you Patient Portal Log in Credentials to the email provided:

______ Yes ______No

I authorize for the following individual(s) to receive information pertaining to any medical history or treatment received:

Name: ____________________________________ Relationship: _____________

Name: ____________________________________ Relationship: _____________

In accordance with Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

- **A. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at (310 Santa Fe Drive, #112, Encinitas, CA 92024). My revocation will be effective once received by Sanjum Samagh, M.D.**
- **B. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.**
- **C. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.**
- **D. A copy of this authorization may be used with the same effectiveness as the original.**

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

Patient or Authorized Representative Signature (Relationship):_________________________________ Date: _____________

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1. **HIPAA Notice of Privacy Practices**
Privacy Officer: Alison Bieda / Yessica Ramirez, 760-690-3133
I hereby acknowledge that I have the right to a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice and a copy of any amended Notice of Privacy practices will be available in the reception area and on our website at all times.

2. **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**
I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:
1. Sanjum Samagh, M.D., uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc.
3.I have the right to revoke this authorization at any time by writing. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4.Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5.Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6.This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE Sanjum Samagh, M.D., TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

3. **Financial Agreement**
In order to provide you with the highest quality of affordable healthcare, we request that our charges for office visits be paid at the conclusion of each visit. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any co-insurance, or any other balance not paid by your insurance. If this account is assign to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection, to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of the patient's records. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I'm entitled, including Medicare, private insurance, and other health plans to the provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am finically responsible for all charges whether or not pain by said insurance. I hereby authorize said assignee to release all necessary information to secure payment. Sanjum Samagh, M.D., Inc. and/or physicians may have a financial or other interest in companies which manufacture or distribute some of the products that are used in the course of your treatment. If you have questions or concerns about a particular product or manufacturer, please let your physician know.

Patient or Authorized Representative Signature (Relationship):______________________________ Date: ____________

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Patient Name: ________________________________
Date of Birth: ________________________________

Age: ______ Sex: M or F Patient SSN: ________________________

Home Address: ____
Street City State Zip

Home Phone: (____) __________________ Cell (____) ____________________ Work (____) ______________________

Email: ______________________________ Employer: ____________________ Occupation: ______________________

Preferred Method of Contact: **[ ] Home** **[ ] Cell** **[ ] Work**

Race (circle): American Indian or Alaska native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Decline
☐ Native Hawaiian or Pacific Islander ☐ White Other ______________________

Ethnicity (circle): Non-Hispanic or Latino Hispanic or Latino Decline

Language: __________________________________ Decline

Marital Status: ____________________________

Insurance information

Primary insurance Co: ___________________________________ Relationship to insured: _________________________

Subscribers Name: ____ Subscribers SSN: ______________________________

Member ID #: ________________________________ Group #: ________________________________ DOB: ________

Secondary insurance Co: ___________________________________ Relationship to insured: _______________________

Subscribers Name: ____ Subscribers SSN: ____________________________

Member ID #: __________________________________ Group #: _____________________________ DOB: ________

Emergency Contact Information

Name: ____ Relationship to patient: __________________________________

Phone: (____) _____________________ Cell (____) ___________________________ Work (____) ___________________

Patient or Authorized Representative Signature (Relationship):____________________________________ Date: _____________

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