Valley Orthopedics, P.L.C.
Gregory H. Sirounian, M.D., P.C.
HIP H&P

NAME: ____________________________________ **DATE:** _____________
AGE: _________________ **DATE OF BIRTH** _________________ **HT:** __________ **WT:** ___________

WHO REFERRED YOU TO THIS PRACTICE: ____

WHO IS YOUR PRIMARY CARE PHYSICIAN: ____

HAVE YOU HAD XRAYS, MRI OR OTHER STUDIES DONE RE: THIS COMPLAINT? ____YES ____NO
IF YES, WHERE: ____

REASON FOR TODAY'S VISIT: _____RIGHT HIP PAIN _____LEFT HIP PAIN _____BOTH
HOW LONG HAS YOU HIP PAIN BEEN PRESENT: _____DAYS _____WEEKS _____YEARS
IS YOUR HIP PAIN RELATED TO AN INJURY _____YES _____NO
IF RELATED TO AN INJURY PLEASE DESCRIBE: ____
____
____

PLEASE CIRCLE THE LEVEL OF PAIN YOU TYPICALLY EXPERIENCE FROM THIS PROBLEM

No pain					Moderate pain					Worst pain
0	1	2	3	4	5	6	7	8	9	10

HIP PAIN LOCATION: _____FRONT _____SIDE _____BACK
DOES YOU PAIN TRAVEL: _____NO _____YES, DOWN THE LEG
WHAT ACTIVITIES MAKE YOUR PAIN WORSE? (CHECK ALL THAT APPLY)
_____WALKING
_____STANDING
_____SITTING
_____UP/DOWN STAIRS
_____STOOPING/BENDING
_____KNEELING
_____OTHER PLEASE DESCRIBE____

DO YOU EXPERIENCE: (CHECK ALL THAT APPLY)
_____LOCKING, CATCHING OR POPPING WITHIN THE HIP
_____LACK OF SENSATION AS IF YOU LEG WAS FALLING ASLEEP
_____HIP DISLOCATION
_____HAVE YOU HAD PRIOR SURGERY OF THE EFFECTED HIP _____YES _____NO
IF SO, DO YOU HAVE _____FEVERS _____CHILLS _____INCISIONAL REDDNESS OR DRAINAGE
DATE(S) OF SURGERY:________________________________
_____PAIN AT NIGHT OR WITH REST
DO YOU USE: _____CANE _____WALKER _____CRUTCHES _____WHEELCHAIR _____NONE
HOW FAR/LONG ARE YOU ABLE TO WALK: ____

PLEASE LIST THE MEDICATIONS OR TREATMENTS HAVE YOU TRIED FOR THIS INJURY/SYMPTOM

____ OVER THE COUNTER ANTI-INFLAMMATORIES REDUCED SYMPTOMS YES / NO
____ PRESCRIPTION MEDICATIONS REDUCED SYMPTOMS YES / NO
____ CORTISONE INJECTION DATE:_________ REDUCED SYMPTOMS YES / NO
____SURGERY IF YES, DESCR IBE WITH APPROXIMATE DATE(S)___________________________________
____ OTHER ______________________________

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH HISTORY & PLEASE EXPLAIN YES RESPONSES

HEART DISEASE/STROKE (HEART ATTACK/ARRHYTHMIA/MURMUR HIGH BLOOD PRESSURE /CHOLESTEROL/PVD)	**NO**	**YES**	______________________________
RESPIRATORY (ASTHMA/EMPHESYMA/COPD/TB)	**NO**	**YES**	______________________________
ENDOCRINE (DIABETES/THYROID DISEASE/ GOITER)	**NO**	**YES**	______________________________
GASTROINTESTINAL (ULCER/REFLUX/HEPATITIS	**NO**	**YES**	______________________________
NEURO/PSYCHOLOGICAL (DEPRESSION/ANXIETY/SEIZURE/MS)	**NO**	**YES**	______________________________
MUSCULOSKELETAL (RHUMATOID ARTHRITIS/GOUT/ FIBROMYALGIA/SPINE PROBLEMS/ OSTEOPOROSIS)	**NO**	**YES**	______________________________
GENITOURINARY (BLADDER PROBLEMS/ENLARGED PROSTATE/HERNIA)	**NO**	**YES**	______________________________
CANCER/ILLNESS (CANCER/AIDS/BLEEDING DISORDER/ BLOOD CLOTS)	**NO**	**YES**	______________________________
OTHER	**NO**	**YES**	______________________________

PLEASE DESCRIBE ALL SURGERIES & APPROXIMATE YEAR THEY OCCURED

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PLEASE LIST ALL CURRENT MEDICATIONS

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO & THE REACTION THAT OCCURS

______________________________ ______________________________
______________________________ ______________________________

DOES ANY FAMILY MEMBER HAVE A HISTORY OF ANY OF THE FOLLOWING
PLEASE CHECK ALL THAT APPLY

_____HEART DISEASE **_____LUNG DISEASE**
_____CANCER **_____THYROID DISEASE**
_____DIABETES **_____TURBERCULOSIS**
_____HEPATITIS **_____BLOOD CLOT**
_____OTHER ____
_____NONE OF THE ABOVE

PLEASE ANSWER AND CIRCLE REGARDING YOURSELF:
EMPLOYED / RETIRED / DISABLED / STUDENT

IF EMPLOYED:
NAME OF EMPLOYER: ____
OCCUPATION: ____

IF STUDENT:
NAME OF SCHOOL: ____
GRADE: __________________

DO YOU DRINK ALCOHOL? HOW OFTEN?
_____NONE ______DAILY _____OCCASIONALLY

DO YOU CURRENTLY USE TOBACCO? SMOKE / CHEW / NONE
I SMOKE_____PACKS PER DAY FOR THE PAST _____YEARS
I QUIT SMOKING _____ YEARS AGO BUT PRIOR TO THAT I SMOKED _____PACKS PER DAY FOR _____YEARS

HISTORY OF SUBSTANCE ABUSE? YES / NO IF YES PLEASE DESCRIBE
____
____

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT APPLY TO YOU:
GENERAL: WEIGHT GAIN/LOSS / LOSS OF APPETITE / FEVER / CHILLS / NIGHT SWEATS
SKIN: RASHES / EASY BRUSING
HEAD: HEADACHES / MIGRAINE / DIZZINESS / FAINTING
EYES, EARS, NOSE: VISUAL CHANGES / NOSE BLEEDING / RINGING IN EARS
MOUTH & THROAT: HOARSENESS / THROAT PAIN / LUMPS
RESPIRATORY: PERSISTANT COUGH / SHORTNESS OF BREATH / WHEEZE
CARDIOVASCULAR: CHEST PAIN / SHORTNESS OF BREATH ON EXERTION / PALPITATIONS
GASTROINTESTINAL: CONSTIPATION / DIARRHEA / INDIGESTION / BLOOD IN STOOL
GENITOURINARY: URINARY FREQUENCY / PAINFUL URINATION / URGENCY OR HESITANCY / BLOOD IN URINE / INCONTINENCE
ENDOCRINE: EXCESSIVE THRIST / EXCESSIVE URINATION / EXCESSIVE HUNGER / COLD OR HEAT INTOLERANCE
MUSCULOSKELETAL: MUSCLE PAIN / JOINT PAIN / JOINT SWELLING
NEUROPSYCHIATRIC: WEAKNESS / MEMORY CHANGES / SLEEP DISTURBANCE

PATIENT REGISTRATION FORM

PATIENT NAME:__________________________ RESPONSIBLE PARTY NAME:________________ BILLING ADDRESS:____ CITY,STATE,ZIP:__________________________________

PERMANENT ADDRESS:____ CITY,STATE,ZIP:__________________________________

HOME PHONE:______________________ BUSINESS PHONE:______________________ CELL PHONE__________________________

PT SOC SEC#:________________________ RESP PARTY SOC SEC#________________________
SEX: MALE FEMALE

PT BIRTHDATE:_____________________ AGE:_____ RESP PARTY RELATIONSHIP TO PT: SELF SPOUSE CHILD OTHER
(PLEASE CIRCLE OPTION)
E-MAIL ADDRESS:____

WHO REFERRED YOU TO OUR PRACTICE?:____

WHAT IS YOUR PRIMARY CARE PHYSICIANS FULL NAME?:____

WHAT ARE YOU BEING SEEN FOR?:____

IF YOUR VISIT IS INJURY RELATED, WAS IT: AN AUTO ACCIDENT OR JOB RELATED? DATE OF INJURY:_____________
(PLEASE CIRCLE OPTION)

IS PATIENT: SINGLE MARRIED WIDOWED DIVORCED OTHER IS PATIENT PREGNANT: YES NO
(PLESAE CIRCLE OPTION)
IS PATIENT: EMPLOYED RETIRED F.T./P.T. STUDENT UNEMPLOYED SELF-EMPLOYED OTHER
(PLEASE CIRCLE OPTION)

EMPLOYER NAME/ADDRESS/PHONE#:____

NEAREST RELATIVE OR FRIEND NAME/PHONE#:____
(SOMEONE OTHER THAN YOUR SPOUSE)

INSURANCE INFORMATION

PRIMARY INSURANCE:
INSURANCE CO. NAME:__________________________________

INSURANCE ADDRESS:__________________________________

POLICY HOLDER NAME:__________________________________

RELATIONSHIP TO PATIENT:____________________________

EMPLOYER:____

SUBSCRIBER ID#:_______________________________________

GROUP/CLAIM#:____

POLICYHOLDER SEX: F OR M BIRTHDATE:____________

SECONDARY INSURANCE:
INSURANCE CO. NAME:__________________________________

INSURANCE ADDRESS:__________________________________

POLICY HOLDER NAME:__________________________________

RELATIONSHIP TO PATIENT:____________________________

EMPLOYER:____

SUBSCRIBER ID#:_______________________________________

GROUP/CLAIM#:____

POLICYHOLDER SEX: F OR M BIRTHDATE:____________

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE VALLEY ORTHOPEDICS, P.L.C. TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT WHICH COULD INCLUDE HIV, COMMUNICABLE DISEASE OR DRUG ABUSE INFORMATION.
AUTHORIZATION TO PAY: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BUSINESS OFFICE OF WEST VALLEY ORTHOPEDICS, P.L.C. FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE.

PATIENT OR RESPONSIBLE PARTY SIGNATURE IF MINOR:____
DATE SIGNED:____________________________

VALLEY ORTHOPEDICS, P.L.C.
FINANCIAL POLICY FORM

Valley Orthopedics, P.L.C., the office of Lawrence P. Shank, M.D., P.C., Gregory H. Sirounian, M.D., P.C., Douglas B. Mangan, M.D., P.C., Grant D. Padley, D.O., Kris Parchuri, D.O. expects payment of your care at the time of service. However, with all verifiable insurance information you will only be expected to pay the deductible, co-payment, co-insurance, or those services not covered or allowed by your insurance.

It is our policy to bill your insurance carrier as a courtesy to you, although you are ultimately responsible for the entire charge when services are rendered. If your insurance carrier does not remit payment within 45 days from the date of service, the balance will be due in full from you. Since we may not be a party to the agreement with you insurance carrier, it is not our policy to contact carriers to establish why they have not paid or why they paid less then originally indicated. Furthermore, your insurance company may have developed a reasonable and customary fee schedule for medical services. These schedules are internal to your insurance company and they may or may not cover all charges incurred during your treatment. These fee schedules often do not reflect standard charges in our geographic area. Please be advised that you are responsible for the total charges or any difference remaining following the payment by your insurance company. Exceptions, if your insurance company is one that **VALLEY ORTHOPEDICS, P.L.C.** participates or holds a contract with, you are only responsible for any patient portion or non-covered service as determined by your insurance carrier.

The above statements do not apply to those patients who are considered **Worker's Compensation.** However, please be advised that as an Industrial Patient, that you may be held responsible for your charges in the event your claim is controverted.

If you fail to make any payments for which you are deemed responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by **VALLEY ORTHOPEDICS, P.L.C.** you will be responsible for all costs of collecting moneys owed, including but not limited to court costs, collection agency and/or attorney fees.

Your signature below indicates that you have read the above information and authorize direct payment from your insurance carrier to **VALLEY ORTHOPEDICS, P.L.C.** and that you understand the financial policy of **VALLEY ORTHOPEDICS, P.L.C.** as it relates to your account.

__________________________________ ______________________________
Patient or Responsible Party **Date Signed**

Authorization for release of medical information to the insurance carrier and assignment of benefits to the physician.
I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to **VALLEY ORTHOPEDICS, P.L.C.** I understand that I am financially responsible for any balance not covered by my insurance carriers. A copy of this signature is as valid as the original.

Signature of patient or legal guardian of patient_______________________________

13555 W. MCDOWELL RD., Suite 302, GOODYEAR, AZ 85395
9250 N. 3rd Street, Suite 2030, Phoenix, AZ 85020
PHONE: (623) 882-1292 FAX: (623) 882-8184

VALLEY ORTHOPEDICS

PATIENT COMMUNICATION SHEET

PATIENT NAME:_________________________________

DATE:________________________

The following instructions pertain to the above named patient:

_____ OK to call home and leave message.

_____ Do not leave message.

_____ Do not call home phone- call only this number.
(_____) ____-_____

_____ Do not call work number.

_____ Call work number only.

_____ Permission to speak only with family members listed below:

____

____

____

____

_____ Do not speak to family members.

Patient or responsible party signature:___________________________

VALLEY ORTHOPEDIC, P.L.C.

13555 W. McDowell Rd., Suite 302, Goodyear, AZ 85395
9250 N. 3rd Street, Suite 2030, Phoenix, AZ 85020
Phone: 623-882-1292 Fax: 623-932-1045

LAWRENCE SHANK. M.D. GREGORY SIROUNIAN, M.D. DOUGLAS MANGAN, M.D.
GRANT PADLEY, D.O. KRIS PARCHURI, D.O.
MICHELLE KUHN, P.A.-C. JULIE PERRY P.A.-C.

OFFICE POLICY
EFFECTIVE IMMEDIATELY

- No patients under the age of 18 will be seen in our office without a written note from legal guardian.
- In the event a patient is unable to keep their scheduled medical appointment with their provider, a phone call must be received by our office 24 hours prior to appointment; otherwise an automatic $25.00 administrative fee may be charged to the patient account.
- We do not bill for co-pays. **PAYMENT IS EXPECTED AT DAY OF SERVICE.**
- Should a patient leave a message with our office, they can anticipate a return call with 24 hours.
- No pain medications or routine medications will be called in by the **ON CALL PROVIDER**. Patients will have to wait until the next working day to discuss with their provider.
- All patients are responsible for making their follow-up appointments and must arrive on time.
- Any patient that arrives 15 minutes after their scheduled appointment may be asked to reschedule. If the patient must be seen secondary to an acute illness, he/she may have to wait to be seen by another provider after his/her case has been reviewed.
- Walk-in patients will be seen only with the provider's authorization.
- At no time, will medical information be shared with another individual/party unless explicitly specified by the patient. (A consent form providing authorization to release medical information must be signed).
- ***This office is not responsible for your insurance benefits.*** Should a diagnostic test and/or procedure be recommended by your provider but is **NOT** covered by your insurance, you will be responsible for **ALL CHARGES**: This also includes charges related to "weight or obesity management".
- If the medical provider feels that you need further diagnostic work up (xrays, etc) or refers to a specialist, it is your responsibility to ensure that those test and/or office visits are completed.
- **AT NO TIME** will inappropriate language be tolerated while on the premises or by phone to any of West Valley Orthopedics staff.
- If a patient misses 3 visits within a year, West Valley Orthopedics reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient to notify of such.

I ____have read Valley Orthopedics, office policy. I will have a copy only if I asked for one. I agree to follow this policy at all times.

____________________________________ ____________________________________ _______/______/_______
Patient or Guardian Signature **Printed Name** **Date**

____________________________________ ____________________________________ _______/______/_______
Witness **Printed Name** **Date**

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POLITCA DE LA OFICINA
EFECTIVO INMEDIATAMENTE

- Ningún paciente bajo la edad de 18 anos cera atendido sin autorización escrita del padre/guardian legal.
- En caso de imprevisto si usted no puede asistir a su cita con su doctor(a), necesitamos recibir una llamada para notificarnos 24 horas antes de su cita, de lo contratrio tendra un cargo administratativo de $25.00.
- Nosotros no mandamos cobros por su co-pago. El pago se espera el mismo dia de servicio.
- Si un paciente deja un mesaje para nuestra oficina, pueden esperar una llamada dentro de 24 horas.
- El doctor(a) de guardia después de horas de servicio no podra hablar para surtir medicinas para el dolor. Pacientestendran que esperar para el proximo dia de servicio de su doctor(a).
- El doctor(a) de guardia no surtira rellenos en sus medicamentos rutinarios. Pacientes tendran que esperar para el proximo dia de servicios.
- Todos los pacientes son responsables de hacer su citas y llegar a tiempo.
- Cualquier paciente que llegue 15 minutos tarde se le pedira que re-programe su cita. Si el paciente necesita atención medica debido a una enfermedad aguda, tendra que esperar para ser atendido por otro doctor(a) después de revisar su caso.
- Pacientes sin cita solo seran atendidos si obtienen autorización por el doctor(a).
- En ningun momento su historial medico sera compartido con ningun grupo/individuo al menos que sea espcificado explícitamente por el paciente. (La forma de consetimeiento autorizando a cierta persona tendra que ser firmada)
- Esta oficina no es responsable or sus beneficios de aseguranza, ustedsera responsable de cubrir todos los cargos. Esto incluye “el manejo de peso/obesidad”.
- En ningun momento lenguaje inapropiado sera tolerado en la oficina o por tlefono a cualquier empleado de West Valley Orthopedics. Tal compotamiento causara la terminacion de su relacion con su doctor(a).
- Si el proveedor medico siente que usted necesita estudios adicionales, o lo refiere a otro especialista usted es responsable de asegurar que esos estudios o citas de oficina son completadas.
- Si un paciente falta a 3 visitas consecutivas, West Valley Orthopedics reserva el derecho de decontinuar la relacion entre doctor(a) y paciente. Una carta cera enviada al paciente para notificar de tal procedimiento.

Yo ________________________________ he leido la poliza de Valley Orthopedics. Yo obtendre una copia solo si lo solicito. Yo acepto seguir esta plaza en todo momento.

______________________________________ ______________________________________ ________/_______/________

Paciente o Guardian Firma **Deletrea** **Fecha**

______________________________________ ______________________________________ ________/_______/________

Testigo **Deletrea** **Fecha**