Rodney Z. Wong, M.D., Inc.
REGISTRATION FORM

Use your legal name and print clearly

ϒLos Altos Office *ϒMorgan Hill Office*

PATIENT DATA

Today' date: _____

Last name: _____ **First name:** _____ **Middle:** _____ ϒMale ϒFemale

Birth date: _____ **Age:** _____ **Social Security Number:** _____

Street address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Number: _____ **Cell:** _____ I prefer to be contacted at ϒHome ϒCell

Email: _____ (We do not share email addresses with third party companies)

Marital Status: ϒSingle ϒMarried ϒDivorced ϒWidowed ϒDecline to Specify

Race: ϒAmerican Indian/Alaska native ϒAsian ϒBlack/African American ϒHawaiian/Pacific Islander ϒWhite ϒDecline to specify

Ethnicity: ϒHispanic/Latino ϒNot Hispanic or Latino ϒDecline to Specify. **Preferred Language:** _____

Employer: _____ **Occupation:** _____

Employer Phone number: _____ **Supervisor:** _____ **Ext#:** _____

Other family members seen here: _____ **Who referred you to our office?:** _____

In case of emergency >Name of friend or relative: _____

Relationship to patient: _____ Phone #: _____

Insurance Subscriber Information

**** Subscriber/Guarantor:** _____ **Birth Date:** _____

Your relationship to Patient: _____ Is subscriber a patient here? ϒYes ϒNo _____

**** If you have provided our office with your insurance card/s, you do not need to fill out the insurance information below.**

Insurance: _____ ID#: _____ Group# _____

**** If the subscriber's address if different from the patient, please provide that address below.**

Subscriber/Guarantor's Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicia n. I understand that I am financially responsible for my balance. I also autho rize Rodney Z. Wong, M.D., Inc., or insurance company to release any information required to process my claims.

Patient /Guardian Signature: _____ Date: _____

MEDICAL HISTORY

Today's Date: _____

Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Family Physician: _____ **Phone:** _____

Pharmacy _____ **Phone:** _____ **Fax:** _____

Pharmacy Street Name & City; _____

Reason for this Visit: ϒShoulder ϒClavicle/Collar bone ϒElbow ϒForearm ϒRibs ϒWrist ϒHand ϒFinger ϒHip ϒKnee ϒCalf ϒAnkle ϒFoot ϒToe/s ϒOther; _____

ϒLeft ϒRight **Onset date:** _____ **Pain level** (10 being unbearable): 1 2 3 4 5 6 7 8 9 10

Symptoms:

ϒ Pain ϒSharp ϒDull ϒIntermittent ϒBurning ϒThrobbing ϒAching ϒCramping
ϒWarmth ϒSwelling ϒPain with Range of motion
ϒJoint Locks up ϒJoint Gives out ϒWake up at night with pain
ϒLimited Range of motion ϒTingling ϒNumbness
ϒOther: _____

How did you injure the area? _____

Did you have any treatment/s? _____

Do you have images of the injured area? ϒY ϒN Where were they done? _____

Do you Smoke?: ϒY ϒN **Packs/cigarettes per day:** _____ **Chew tobacco?:** ϒY ϒN **How often:** _____

Do you drink alcohol? ϒY ϒN What kind? _____ Glasses/Cans: _____

Allergies: _____

Severity: ϒVery Mild ϒMild ϒModerate ϒSevere **Allergy Reaction/s**: ϒRash ϒHives ϒOther: _____
Onset: ϒUnknown ϒAdulthood ϒChildhood _____

Current Medications: name _____ dosage _____ frequency _____

name _____ dosage _____ frequency _____

name _____ dosage _____ frequency _____

**** If you have additional medications, please provide a separate list ****

Have you been tested positive for any contagious diseases? ϒY ϒN **If yes, explain;** _____

Medical History:

ϒHypertension	ϒPregnancy/ Breast Feeding	Other:
ϒDiabetes	ϒHigh Cholesterol	_____
ϒHeart Disease	ϒStroke	_____
ϒPeptic Ulcer/Reflux	ϒRheumatoid Arthritis	_____

Past Surgical History:

ϒHeart Surgery	ϒHysterectomy	Other:
ϒAppendix Removal	ϒCarpal Tunnel Release	_____
ϒTotal Replacement	ϒArthroscopy	_____
Knee / Hip / Shoulder	Knee / Shoulder / Elbow	_____

Family History:

Mother = ϒCancer ϒDiabetes ϒHeart ϒStroke ϒBleeding ϒHypertension ϒTB ϒOther _____
Father = ϒCancer ϒDiabetes ϒHeart ϒStroke ϒBleeding ϒHypertension ϒTB ϒOther _____

Rodney Z. Wong, M.D., Inc.

Acknowledgements of Receipt

Notice of Privacy Practices

Our "Notice of Privacy Practices" provides information about how Rodney Z. Wong, M.D., Inc. may use and disclose your protected health information. We encourage you to read it in full. If you have any questions about our "Notice of Privacy Practices", you are welcome to contact the office.

Notice of Office Payment Policy

Our "Office Payment Policy" provides information about our office's billing and payment policies, including fees for non-payment. These policies may be changed or amended. You can obtain a copy of the revised notice by calling the office at 650-967-7249, or by visiting our website, www.rodneywongmd.com.

Notice of General Policies and Procedures

Our "General Office Policies and Procedures" provides information about our office policies and procedures, including Cancelling and Re-scheduling Appointments; Missed Appointment Fees; Copy of Records; Filling Out Forms; and Fees. These policies may be changed or amended.

By signing this form, I acknowledge:

- Receipt of the "Notice of Privacy Practices" for Rodney Z. Wong, M.D., Inc.;
- Receipt of the "Notice of Policies and Procedures: Office Payment Policy" for Rodney Z. Wong, M.D., Inc.;
- Receipt of the "Notice of Policies and Procedures: General Office Policies and Procedures" for Rodney Z. Wong, M.D., Inc.;
- That each policy may be changed or amended at any time;
- And, that I can obtain a copy of any of these notices by calling the office at 650-967-7249, or by visiting the website, www.rodneywongmd.com.
- Agree to receive automated text and voice messages to phone numbers listed on patient's profile.

Patient Name or Legal Representative (please print): _____

Signature: _____ Date: _____

If signed by someone other than patient, indicate relationship: _____

Patient Name: _____

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

PURPOSE . The purpose of this form is to obtain your consent for telemedicine consultation with **Dr. Rodney Wong**. The purpose of this consultation is to assist in the diagnosis or treatment in the areas of Orthopedic and Sports Medicine.

NATURE OF TELEMEDICINE CONSULTATION. Telemedicine consultation involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

RISKS BENEFITS AND ALTERNATIVES. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

MEDICAL INFORMATION AND RECORDS. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

CONFIDENTIALITY. All existing confidentiality protections under federal and California law apply to information used or disclosed during your telemedicine consultation.

RIGHTS. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

Dr. Rodney Wong, has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to a telemedicine consultation.

_____ _____

Signature of Patient or Patient's Representative **Date of Signing**

_____ _____

Relationship of Representative to Patient **Signature of Witness (if patient unable to sign)**

REFUSAL: I refuse to participate in a telemedicine consultation.

Signature: _____