CALIFORNIA HAND AND WRIST ASSOCIATES

A Medical Corporation

Aileen Shieu, M.D. — Certified American Board of Surgery ● QME
James L. Pertsch, M.D., F.A.C.S. — CAQSH ● Certified Added Qualification Surgery of the Hand ● QME

PATIENT INFORMATION

I. Personal Information

Name ____ Day Phone (____)________________________

Address ____ Cell/Evening phone (____)__________________

City _________________________Zip__________ Private e-mail _______________________________

Patient Social Security (SS)# _______________________ Insured SS# ___________________________

Patient Date Of Birth (DOB) ________________Age ____ Insured DOB ___________________________

How did you hear about us? ____

II. Emergency Contact

Name_____________________________ Cell Phone(____)__________ Daytime Phone(____)__________

III. Medical Information

Do you see other physicians? No Yes: Name(s) _____________________________ City ________________
Allergies to any medications? No Yes: ____
Any medical conditions? No Yes: ____

Medication, herbs, vitamins, or diet pills taken? No Yes: ____
Do you have an Advance Directive? No Yes if yes, please provide a copy for your chart.

PLEASE NOTE: Do **NOT** take **aspirin** or aspirin-containing products, **vitamin E,** herbal supplements, weight loss medications (prescription and/or non-prescription), or **anti-inflammatories** (Advil, Motrin, ibuprofen, Aleve, etc.) for two weeks before your surgery.

** Medicare requires all non-narcotic prescriptions to be paperless, that is, prescribed via the Internet. If you are a Medicare patient OR you would like paperless prescriptions, please provide the name and location of your pharmacy:

____

IV. Patient Confidentiality:

May we show photos/xrays taken of your condition to others in our office, in presentations, and our websites? (Your name and other identifying info will not be disclosed.) Yes No

V. Financial Policy Acknowledgement, Payment Authorization, and Disclosures

We expect each patient to be personally responsible for all charges. Payment is expected at time of service. I authorize $100 charge if I alter/cancel appointment with less than one business day notice given to this office, or if I 'no show'. A $35 fee will be assessed for each returned check. As a courtesy, we may be able to bill your insurance company on your behalf. I authorize the staff at California Hand and Wrist Associates, A Medical Corporation ("CHW"), to furnish all information necessary to process insurance claims, address work status issues, and complete disability forms. Please volunteer any copay due before seeing the doctor as billed copay is subject to $15 processing fee. Services on a prepaid basis will not be billed to insurance. Drs. James and Suzanne Pertsch are the sole owners of the ABJ Surgery Center, Inc. A Medical Corporation ("ABJ") and benefit financially from its use. Dr. Pertsch may need to suggest alternate physician if surgery cannot be accomplished at ABJ. ABJ is out-of-network for most insurance plans. Anesthesiologists or physicians to whom patients may be referred are independent agents not employees of Dr. Shieu, Pertsch, ABJ, or CHW. I have reviewed and understood the (HIPAA) Notice of Privacy Practices.

Patient Signature: _____________________________________ **Date:** __________________

Staff Signature: _____________________________________

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❑ 104 St. Matthews Avenue San Mateo California 94401 Tel 650.344.8700 Fax 650.344.8187
❑ 2485 Hospital Drive, Suite 361 Mountain View California 94040 Tel 650.210.8181 Fax 650.210.8585

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

	PLEASE DO NOT USE THIS COLUMN
1. **INSURER NAME AND ADDRESS**	
2. **EMPLOYER NAME**	Case No.
3. Address No. and Street City Zip	Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)	County
5. **PATIENT NAME** (first name, middle initial, last name) / 6. Sex ☐ Male ☐ Female / 7. Date of Birth Mo. Day Yr.	Age
8. Address: No. and Street City Zip / 9. Telephone number ( )	Hazard
10. Occupation (Specific job title) / 11. Social Security Number - -	Disease
12. Injured at: No. and Street City County	Hospitalization
13. Date and hour of injury or onset of illness Mo. Day Yr. Hour ______ a.m. ______ p.m. / 14. Date last worked Mo. Day Yr.	Occupation
15. Date and hour of first examination or treatment Mo. Day Yr. Hour ______ a.m. ______ p.m. / 16. Have you (or your office) previously treated patient? ☐ Yes ☐ No	Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

Hobbies:

Time at this job:

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)

A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

Married: Y / N
Children: Y / N Ages:
Are you R or L Handed?
Prior Hand Injuries:

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☐ No

ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐ Yes ☐ No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes ☐ No

If "no", date when patient can return to: Regular work ___/___/___
Modified work ___/___/___ Specify restrictions ______________________

Doctor's Signature ______________________ CA License Number G62677 / A100363

Doctor Name and Degree (please type) **James L. Pertsch, MD / Aileen Shieu, MD** IRS Number 200250546

Address 104 St. Matthews Ave., San Mateo, CA 94401
515 S. Drive, Ste 16, Mountain View, CA 94040
Telephone Number (650) 344-8700

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Any person who makes or causes to be made any knowingly false or fradulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.