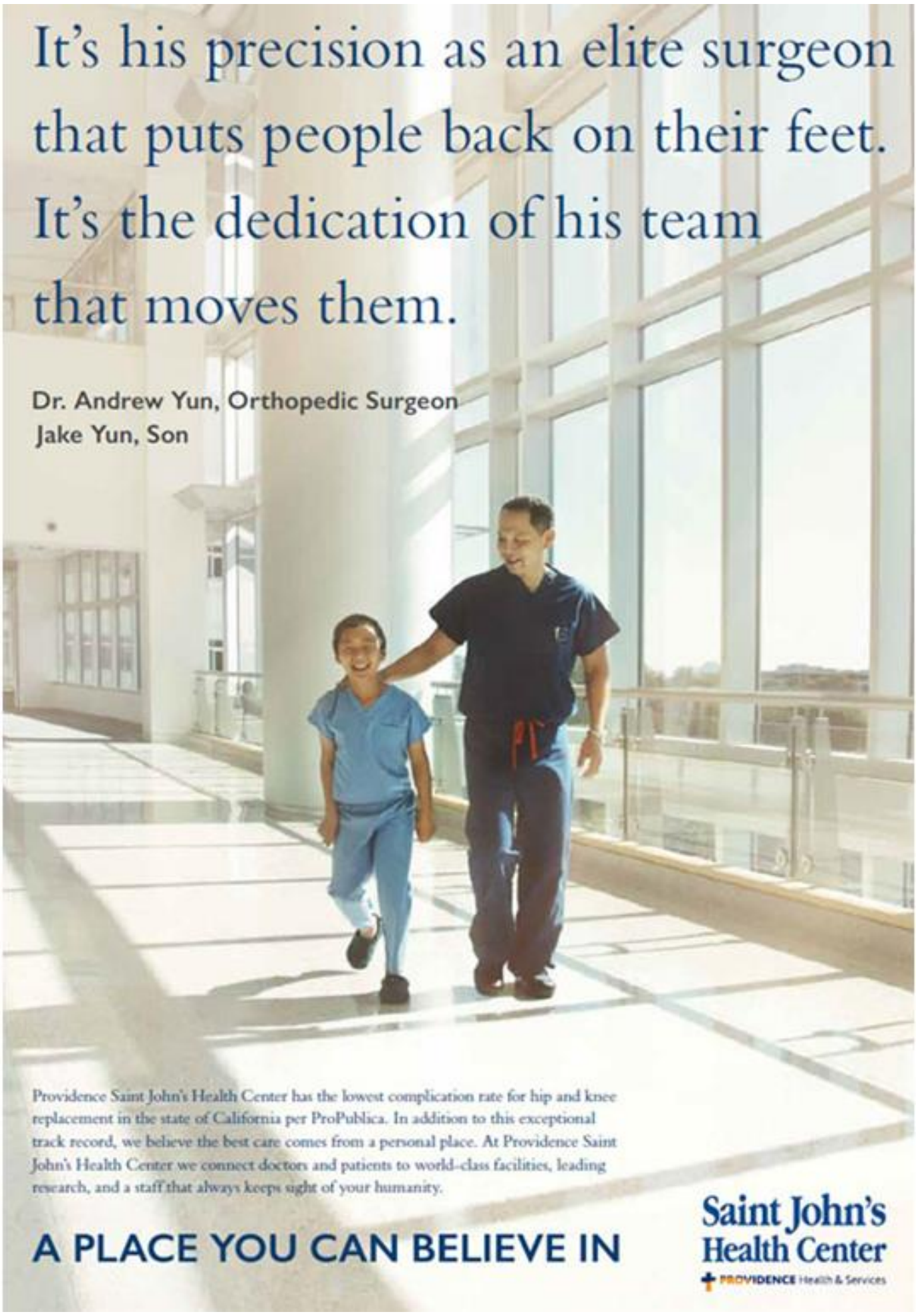
It's his precision as an elite surgeon that puts people back on their feet. It's the dedication of his team that moves them.
Dr. Andrew Yun, Orthopedic Surgeon
Jake Yun, Son
Providence Saint John's Health Center has the lowest complication rate for hip and knee replacement in the state of California per ProPublica. In addition to this exceptional track record, we believe the best care comes from a personal place. At Providence Saint John's Health Center we connect doctors and patients to world-class facilities, leading research, and a staff that always keeps sight of your humanity.
A PLACE YOU CAN BELIEVE IN
Saint John's Health Center
PROVIDENCE Health & Services

Saint John's Health Center
PROVIDENCE Health & Services

Center For Hip & Knee Replacement

2001 Santa Monica Blvd., Suite #760W
Santa Monica, CA 90404
(310) 582-7474 (Office)
(310) 582-7481 (Fax)
http://california.providence.org/saint-johns/services/orthopedics/
http://www.totaljoints.net/

Dear Patient:

Welcome to Providence Saint John's Center For Hip and Knee Replacement.
We thank you in advance for choosing our practice and look forward to meeting you.
Our goal is to provide you with the best possible patient experience.

Please review the below items in preparation for your visit.

- ❑ Bring completed patient forms
- ❑ Bring applicable insurance card(s).
- ❑ Bring valid government issued picture identification.
- ❑ Bring images from an outside facility (if applicable).
- ❑ Wear comfortable loose clothing
- ❑ Parking is available behind our building. Entrance is off 20th Street, 100 feet north of Santa Monica Blvd. Fee is $2.50 every 15 minutes with a maximum of $17.50 per day. Cash and check are only accepted. We do not validate.

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Center For Hip & Knee Replacement

FACILITY FEE NOTIFICATION

Dear Patient:

Thank you for considering Providence Saint John's Health Center. We would like to provide you with information regarding the billing process. Our practice is a department of Providence Saint John's Health Center. As a result, you will receive a bill from Saint John's Health Center, as well as one from our physician who provides professional services. This is because our office is considered to be a hospital based practice. Medicare and most insurance companies require that patients make two payments (one to the surgeon and one to the facility) for care received in provider clinics.

All visits to the clinic will result in a 'facility fee' in addition to any tests or procedures. Like other fees, the 'facility fee' is usually covered by your insurance, resulting in you being responsible for the co-payment only. The hospital will also charge a technical fee for any tests or procedures (such as x-rays). If your visit or procedure is covered by insurance benefits, the insurance company will decide the amount you are responsible for paying.

We would appreciate you signing this letter below and returning it with your registration information. Please feel free to contact us if you have any questions.

Patient Signature **Date**

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REGISTRATION FORM

Patient Information

Name_____**Date of Birth** / /_____

Gender **Marital Status:** _____

Phone # (Home) _____ **(Cell)** _____

Social Security # _____ **Religion**_____

Race_____ **Country and State of Birth**_____

Billing Address _____

City_____ **State**_____ **Zip Code** _____

E-Mail_____

Emergency Contact

Name _____ **Relationship to pt.** _____

Address _____

City_____ **State**_____ **Zip Code** _____

Phone _____

Employment Status

☐ **Full Time** ☐ **Part Time** ☐ **Not Employed** ☐ **Self Employed** ☐ **Retired**

Date of retirement (if applicable**)** _____ **Spouse Retired?** (if applicable)_____

Date of spouse retirement (if applicable) _____

Employer Name: _____ **Occupation:** _____

Address: _____ **City:** _____

Zip Code: _____ **Phone:** _____

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Please take a moment to let us know how you heard about our practice

Please check all that apply

☐ Physician Referred (complete below)

☐ Self Referred_____
(internet? website? etc.)

☐ Friend / Family / Former Patient

☐ Advertisement_____
(internet? email? etc.)

Please complete the information regarding your physician(s)

Referring Physician

Name _____

Address _____

City_____ **State**_____ **Zip Code** _____

Phone Number _____

Primary Care Physician

Name _____

Address _____

City_____ **State**_____ **Zip Code** _____

Phone Number _____

Cardiology Physician

Name _____

Address _____

City_____ **State**_____ **Zip Code** _____

Phone Number _____

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Health History Questionnaire

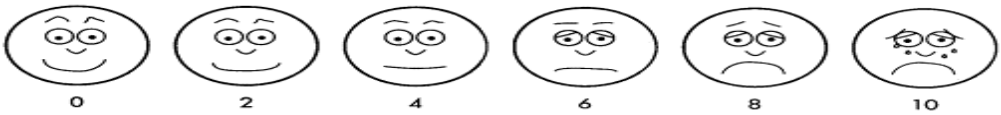
Name: _____ Age_____

Where is your pain? ☐ Hip ☐ Groin ☐ Buttock ☐ Knee ☐ Low back

Which side? _____ ☐ Other: _____

How long have you had the pain? _____

How bad is your pain (on a scale of 0-10; 10 being worst)?



No Pain | Pain can be ignored | Interferes with tasks | Interferes with concentratrion | Interferes with basic needs | Bed rest required

Pain is worsened by: (Check all that apply)

☐ Walking ☐ Standing ☐ Stairs ☐ Hills ☐ Uneven ground ☐ Getting dressed

☐ Work ☐ Exercise ☐ Sports ☐ Travel ☐ Cold weather

Other symptoms: (Check all that apply)

☐ Limp ☐ Fatigue ☐ Grinding ☐ Swelling ☐ Weakness

☐ Falling ☐ Stiffness ☐ Clicking ☐ Locking ☐ Pain at Night

Do you use the following devices?(Check all that apply)

☐ Brace ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair None

What treatment have you had for the pain?(Check all that apply)

☐ Tylenol ☐ Bracing ☐ Trainer ☐ Shoe lift ☐ Time off work

☐ Ice ☐ Cortisone ☐ Wt.loss ☐ Rest Cane ☐ Glucosamine

☐ Injections ☐ Chiropractic ☐

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Health History Questionnaire

What treatment have you had for the pain?(continued)

Do you currently take narcotic pain medication?

Name of medication _____

Have you had previous surgery **?** If yes, describe type and date performed.

_____

_____

Please check any medical problems that apply

☐ Diabetes ☐ Hypertension ☐ Kidney disease ☐ Seizures ☐ Prior Staph Infection

☐ Stroke ☐ Depression ☐ High anxiety ☐ Asthma ☐ History of ulcers

☐ HIV ☐ Fibromyalgia ☐ Sleep apnea ☐ Irregular heart beat ☐ Motion sickness

☐ Dementia ☐ Congestive heart failure ☐ Post-operative nausea

☐ Cancer (type: _____) ☐ Hepatitis (type:_____)

☐ Blood clots (where/when)_____ ☐ Bypass surgery (when)_____

☐ Cardiac stents (when:_____ ☐ Prosthetic heart valve

☐ Other_____

Are you currently having problems with any of the following conditions? Check all that apply

☐ Constipation ☐ Bladder ☐ Bleeding ☐ Numbness/tingling ☐ Circulation problems

☐ Digestive ☐ Balance ☐ Hormonal ☐ Drug addiction

Family History: (check all that apply)

Father Cause of death: _____

Mother Cause of death: _____

Brother Cause of death: _____

Sister: Cause of death: _____

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PAIN ASSESSMENT QUESTIONNAIRE

To better understand your needs, we would like to know the types of thoughts and feelings that you have when you are in pain. Below are statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

PLEASE ONLY CHECK ONE FROM EACH ROW	Not at all	To a **slight** degree	To a **moderate** degree	To a **great** degree	All the time
I worry all the time about whether the pain will end					
I feel I can't go on					
It's terrible and I think it's never going to get any better					
It's awful and I feel that it overwhelms me					
I feel I can't stand it anymore					
I become afraid that the pain will get worse					
I keep thinking of other painful events					
I anxiously want the pain to go away					
I can't seem to keep it out of my mind					
I keep thinking about how much it hurts					
I keep thinking about how badly I want the pain to stop					
There's nothing I can do to reduce the intensity of the pain					
I wonder whether something serious may happen					

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PHARMACY & MEDICATION LIST

Name of preferred pharmacy: _____

Address_____ City _____

Zip Code _____ Phone Number _____

	Name of Medication **Include prescription, over-the-counter, samples, vitamins, vaccines, herbal products, respiratory treatments, parenteral nutrition, supplements, and any other FDA substance listed as a drug.**	**Dose**	**Frequency**	**Reason For Medication**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Patient Signature **Date**

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KNOWN ALLERGIES

Height: _____ Weight: _____ ☐ **scale** ☐ **self report**

Type	List / Describe reaction	Reaction: R = Rash D = Difficulty breathing G= GI upset
Medication		
Food		
Environmental		
Latex Products		
Allergy Band		
Other		

Patient Signature **Date**

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OUTSIDE IMAGING INFORMATION

Please complete the information below if you're bringing in X-ray or MRI to your visit. Images must be taken within the past 12 months in order to be evaluated.

X-RAY (Must be within the past 12 months)

☐ **KNEE** ☐ **Left** ☐ **Right**
☐ **HIP** ☐ **Left** ☐ **Right**

Date Taken _____

Name of Facility _____

Address of Facility _____

_____

MRI (Must be within the past 12 months and report **must** be included)

☐ **KNEE** ☐ **Left** ☐ **Right**
☐ **HIP** ☐ **Left** ☐ **Right**

Date Taken _____

Report included ☐ Yes ☐ No

Name of Facility _____

Address of Facility _____

_____