Welcome to Providence Saint John's Center for Hip & Knee Replacement

The Offices of Dr. Benjamin C. Bengs, M.D.
and Dr. Andrew G. Yun, M.D.

Respect. Compassion. Justice. Excellence. Stewardship.

Saint John's Health Center
PROVIDENCE Health & Services

The Center for Hip & Knee Replacement
Dr. Benjamin C. Bengs
Dr. Andrew G. Yun

2001 Santa Monica Blvd., Suite #760
Santa Monica, CA 90404
(310) 582-7474 (Office)
(310) 315-6190 (Fax)

Dear Patient:

Welcome to Providence Saint John's Hip & Pelvis Institute and Center for 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.

Attached you will find several documents that we ask you review and complete prior to your scheduled appointment.

Please review the below items in preparation for your visit.

- ❑ Completed patient forms.
- ❑ Applicable insurance card(s).
- ❑ Valid government issued picture identification.
- ❑ Images from an outside facility (if applicable).
- ❑ Wear comfortable loose clothing.
- ❑ We offer parking, but we do not validate. Fee is $2.50 every 15 minutes with a maximum of $17.50. Cash and check are only accepted at the moment.

We kindly ask that you arrive at least 15 minutes prior to your scheduled appointment to allow ample time for registration. Again, thank you for choosing Providence Saint John's for your healthcare needs. We look forward to meeting you and exceeding your expectations.

Saint John's Health Center
PROVIDENCE Health & Services

Office Use only
Patient Label

The 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**

Saint John's Health Center
PROVIDENCE Health & Services

The Center for Hip & Knee Replacement

Office Use Only
Patient Label

REGISTRATION FORM

Patient Information

Name_____**Date of Birth** _____/_____/_____

Sex: M / F Marital Status: Single Married Divorced Widowed

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

Social Security # _____ **Religion**_____

Race_____ **Country and State of Birth**_____

Home Address _____

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

E-Mail_____

Emergency Contact

Name _____ **Relationship to pt.** _____

Address _____

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

Phone _____

Employment Status

Employment Status: F/T_____**Part Time**_____ **Not Employed**_____ **Date Retired**_____

Employer Name: _____ **Occupation:** _____

Address _____

City_____ **Zip Code**_____ **Phone**_____

Saint John's Health Center
PROVIDENCE Health & Services

The Center for Hip & Knee Replacement

Office Use Only
Patient Label

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

Please circle appropriate response

- Physician Referred (complete below)
- Self Referred_____ (internet? website? etc.)
- Friend / Family / Former Patient
- Advertisement_____ (internet? email? etc.)

Please complete the referring and primary care physician's information if applicable.

Referring Physician

Name _____

Address _____

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

Phone Number _____

Fax Number _____

Primary Care Physician

Name _____

Address _____

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

Phone Number _____

Fax Number _____

Saint John's Health Center
PROVIDENCE Health & Services

The Center for Hip & Knee Replacement

Office Use Only
Patient Label

Chief Complaint:

_____

_____

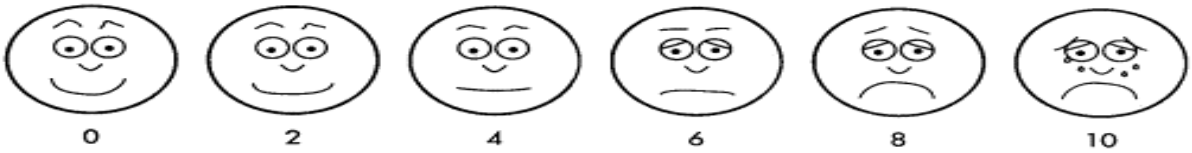
_____

_____

Previous orthopedic surgeries, year performed:

_____

_____



0	2	4	6	8	10
No Pain	Pain can be ignored	Interferes with tasks	Interferes with concentration	Interferes with basic needs	Bed rest required

Do you use the following devices? • Brace • Cane • Crutches • Walker • Wheelchair • None

What treatment have you had for the pain?

• Pain medication • Anti-inflammatories • Glucosamine • Tylenol • Narcotics • Rest Cane

• Ice • Physical therapy • Trainer • Weight Loss • Bracing • Chiropractic

• Acupuncture • Shoe lift • Cortisone • Injections

Do you take narcotic pain medication currently? Yes No Type:_____

Saint John's Health Center
PROVIDENCE Health & Services

Office Use Only
Patient Label

The Center for Hip & Knee Replacement

Please check any **medical problems** that apply:

- □ Diabetes
- □ Blood Clots
- □ Hypertension
- □ Cancer
- □ Kidney disease
- □ Pacemaker
- □ Stroke
- □ Irregular heart beat
- □ Seizures
- □ Bypass surgery
- □ Asthma
- □ Cardiac stents
- □ Prior staph infection
- □ Prosthetic heart valve

□ Other _____

Social History:

Marital Status Single Married Divorce Widow

Do you currently smoke tobacco? Yes No

Do you drink alcohol? Yes No Social Heavy

Are you involved in litigation related to this problem Yes No

Family History (if significant):

Medication Allergies (please do not include if minor reaction eg upset stomach):

Favorite activity (eg golf, reading, movies, etc):

Saint John's Health Center
PROVIDENCE Health & Services

The Center for Hip & Knee Replacement

Office Use Only
Patient Label

MEDICATION LIST

List of Patient's Current Medications

	Name of Medication	Dose	Frequency	Reason For Medication
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Patient Signature **Date**