CALIFORNIA PACIFIC ORTHOPAEDICS

PATIENT REGISTRATION FORM

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PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birthdate: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity:	Language:

Street Address:	Social Security #:	Contact Phone #: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone #: ( )

How did you hear of us? ❑ Website ❑ Dr. ____________________ ❑ Advertisement ____________________ ❑ Social Media _______________

❑ Insurance Plan ❑ Family ❑ Friend ❑ Yelp ❑ Yellow Pages ❑ Hospital ❑ Other

Patient's e-mail address:

Referring Physician : ____Tel #: ______________________________

Primary Care Physician (if different from above):____ Tel:#______________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Insurance guarantor:	Birthdate: / /	Address (if different from above):	Contact Phone #: ( )

Primary insurance name:

Secondary insurance name:

Subscriber's name:	Birthdate: / /	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

WORKERS COMPENSATION ONLY				
Date of Injury:	Claim #:	Workers Compensation Insurance Carrier:		
Carrier Address:	City:		State:	Zip Code:
Claims Adjuster:	Phone #: ( )	Fax#: ( )		
Attorney:	Phone #: ( )	Fax#: ( )		
Employer:				
Are you currently working? (please indicate part-time/full-time/light duty):				
Do you have a primary treating physician for this case?:				
Is there anything else we should know about your claim?:				

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize CALIFORNIA PACIFIC ORTHOPAEDICS or insurance company to release any information required to process my claims.

Patient/Patient Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES

We want you to know that we respect and protect the privacy of your personal information. As healthcare providers, we are governed by the Health Insurance Portability and Accountability Act (HIPAA) and the "Privacy Rule". As such, we need your consent for the use and disclosure of your personal healthcare information (PHI) in order to carry out your treatment.

It is our policy to properly determine the appropriate uses of PHI in accordance with the government rules, laws and regulations. As a part of this plan, we have implemented a compliance program that oversees the use of PHI. All employees, managers and physicians continually undergo training on how to comply with government rules and regulations regarding HIPAA and the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients. Only when it is deemed appropriate and necessary to carry out treatment, payment or other healthcare operations will we provide other entities with your PHI (examples of such entities are hospitals, surgery centers, laboratories, insurance and billing companies and imaging services).

You have the right to revoke this consent except where we have already made disclosures based upon your prior consent. You may use our "Authorization for Release of Information Form" to revoke consent or you may simply send us a letter.

I have read and understand the policy as outlined above. I authorize California Pacific Orthopaedics to use and disclose my PHI for treatment, payment or other healthcare operations. I understand that if I do not sign this form California Pacific Orthopaedics has the right to refuse to treat me.

____

Signature of Patient/Legal Guardian **Relationship**

____

Patient Name (Print) **Today's Date**

Patient Consent

I authorize California Pacific Orthopaedics to release information pertaining to my treatment and care to the following person(s):

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

CALIFORNIA PACIFIC ORTHOPAEDICS

OFFICE POLICIES & PATIENT FINANCIAL AGREEMENTS

PAYMENT FOR SERVICES RENDERED

I agree to pay my account balance at the time of service or make financial arrangements to pay my balance at a future date. If co-payments, deductibles, out-of-network balances, non-covered services and/or past due balances are designated by my insurance company or health plan, I agree to pay those balances directly to California Pacific Orthopaedics. If my account is delinquent I understand that it may be turned over to a collection agency.

NON-PARTICIPATING INSURANCE & SELF-PAY ACCOUNTS

I understand that my account will be deemed as self-pay if I do not present verifiable insurance coverage at the time of service. I also understand that my account will be deemed self-pay if the practice is not contracted with my insurance company. I understand and agree that I am individually obligated to pay the full charges at the time of service if my account is deemed self-pay. I understand that it is MY responsibility to inform the practice of any insurance coverage changes, to confirm the practice's participation with my insurance company and to verify eligibility before each visit, procedure or surgery.

HMO REFERRALS & AUTHORIZATIONS

If I participate in an HMO plan I understand that I must obtain prior authorization from my Primary Care Provider (PCP) prior to services being provided to me. I understand that if authorization is not provided to the practive that I will be asked to reschedule my appointment or pay in full for services at the time of visit.

NON-COVERED SERVICES

I understand that California Pacific Orthopaedics contracts with health care service plans that relate only to items and services which are "covered" by the health care service plans. Accordingly, I accept full responsibility for all items or servies which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan furnished to the patient.

SURGERY CANCELLATION

Failure to arrive for a scheduled surgery and/or failure to cancel the surgery 5 business days prior to the surgery date will result in a missed surgery fee of $500 for each occurrence. This fee cannot be billed to the insurance. I understand that I will be responsible for payment. If the primary care provider has not given clearance for the surgery, the surgery scheduling coordinator must be contacted at 415-668-8010.

RETURNED CHECKS

All returned checks will be assessed a $35 fee for each check. This fee cannot be billed to insurance. I understand that I will be responsible for payment.

MISSED APPOINTMENTS

Failure to arrive for scheduled appointments and/or failure to cancel appoinemtns within 24 hours of the appointment time will result in a missed appointment fee of $75 for each occurance. The missed appoiontment fee cannot be billed to the insurance. I understand that I will be responsible for payment.

MEDICAL RECORDS REQUESTS
An advance payment is required for copies of medical records, radiology images and/or radiology reports. The fee may vary depending on medical record needs. This cannot be billed to the insurance. I understand that I will be responsible for payment.

DISABILITY FORMS
An advance payment of $25 is required for completion of each insurance disability form (excluding California State Disability and Worker's Compensation forms). This cannot be billed to the insurance. I understand that I will be responsible for payment.

REFUND REQUESTS
Overpayments will be refunded within 30 days of California Pacific Orthopaedics' confirmation of the refund request.

ASSIGNMENT OF BENEFITS
I authorize the release of any information necessary to my insurance carrier or other medical entity to determine benefits or benefits payable. A copy of this authorization may be sent to my insurance company or other entity if requested.

I have read and understand the policies as outlined above. I understand that by signing this form I am consenting to the office policies and accepting financial responsibility for services received.

____

Signature of Patient | Date

____

Signature of Legal Guardian | Date/Relationship

____

Patient Name (print) | Date

CALIFORNIA PACIFIC ORTHOPAEDICS

PATIENT MEDICAL HISTORY

Today's Date: ____________________ MRN: ______________________

Patient Name: ____ Birth Date: ______________________ ❑ Male ❑ Female

Date of Injury: _______________________ ❑ Work-related ❑ Auto accident injury I am ❑ right-handed ❑ left-handed

Occupation:___________________________ Primary Care Physician:__________________ Referring Physician: _______________

HISTORY OF PRESENT ILLNESS

Height: ______ft. _______in **Weight:** ________lbs. **Age:** ________ **Problem with:** ❑ **Right Extremity** ❑ **Left Extremity**

Chief complaint / Where is the pain or problem? ____

Does pain travel to other areas? ❑ No ❑ Yes If yes, where? _____________ **How long have you had the pain/problem?** _____

What were you doing when the pain started? ____

How severe is the pain on a scale of 1-10 with 10 being most severe? ____

What does it feel like? ❑ sharp ❑ burning ❑ dull ❑ achy ❑ other ____

Timing: Is the pain: ❑ intermittent ❑ constant ❑ worse at night ❑ worse with or after activity ❑ other ________________________

Associated problems include: ❑ numbness/tingling ❑ locking or catching ❑ popping ❑ grinding ❑ clicking ❑ instability

❑ swelling ❑ stiffness ❑ night pain ❑ other ____

What makes the pain/problem better or worse? ____

Have you tried: Anti-inflammatories (ie. Advil, Aleve, etc) ❑ No ❑Yes If yes, did it help ❑ No ❑ Yes

Physical therapy ❑ No ❑ Yes If yes, did it help ❑ No ❑ Yes

Steroid injections ❑ No ❑ Yes If yes, did it help ❑ No ❑ Yes

Have you seen any other orthopedic physicians regarding this condition prior to coming to our office? ❑ No ❑ Yes

If yes, who did you see and what treatments were prescribed? ____

In the past, have you experienced any injury or symptoms regarding this body part? ❑ No ❑ Yes

If so, please describe____

Please list any hobbies/sports you enjoy: ____

Which of the above activities are you unable to perform due to your pain? ____

Are you being treated for any of the following medical conditions:

- ❑ AIDS / HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Bleeding Problems
- ❑ Blood Transfusions
- ❑ Diabetes
- ❑ Epilepsy / Seizures
- ❑ Heart disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Kidney Disease
- ❑ Metal in Body
- ❑ Migraine Headaches
- ❑ Neck Pain
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Other (please list)

____

____

Allergies to medications, the environment and food - please list name and reaction(s):

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

Latex Allergy ❑ No ❑ Yes

Egg Allergy ❑ No ❑ Yes

Medications (include non-prescription & herbal supplements):

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Past surgical/hospitalization history:

Year	Surgery/Illness	Year	Surgery/Illness

Patient Social History:

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation
❑ Single	❑ Never	❑ Never	❑ With spouse
❑ Married	❑ Rarely	❑ Previously, but quit	❑ With children (how many ___)
❑ Divorced	❑ Moderate	❑ Currently	❑ Alone
❑ Widowed	❑ Daily	Amount per day____	❑ Other ___________
❑ Separated			

Family Medical History - please list any medical problems for the following family members:

Father: ____

Mother: ____

Siblings: ____

Review of Systems: Please indicate any personal history below (circle all that apply)

Musculoskeletal

Joint pain (other then current pain)	No Yes
Weakness of muscles or joints	No Yes
Back pain	No Yes
Difficulty in walking	No Yes

Constitutional Symptoms

Recent weight change	No Yes
Fever	No Yes
Fatigue	No Yes
Headaches	No Yes

Ears / Nose / Mouth / Throat

Hearing loss	No Yes
Chronic sinus problems	No Yes
Bleeding gums	No Yes
Swollen glands in neck	No Yes

Cardiovascular

History of heart attack	No Yes
Chest pain	No Yes
Abnormal heart rhythm	No Yes

Genitourinary

Frequent urination	No Yes
Burning or painful urination	No Yes
Incontinence	No Yes

Female History

Currently pregnant	No Yes
Number of pregnancies	______
Number of deliveries	______

Skin

Rash	No Yes
Varicose veins	No Yes
Skin disease	No Yes

Neurological

Numbness or tingling sensations	No Yes
Tremors	No Yes
Paralysis	No Yes

Endocrine

Excessive thirst	No Yes
Heat or cold intolerance	No Yes

Hematologic / Lymphatic

Bleeding tendency	No Yes
Anemia	No Yes
Swelling of extremities	No Yes

Psychiatric

Memory loss	No Yes
Anxiety	No Yes
Depression	No Yes
Insomnia	No Yes

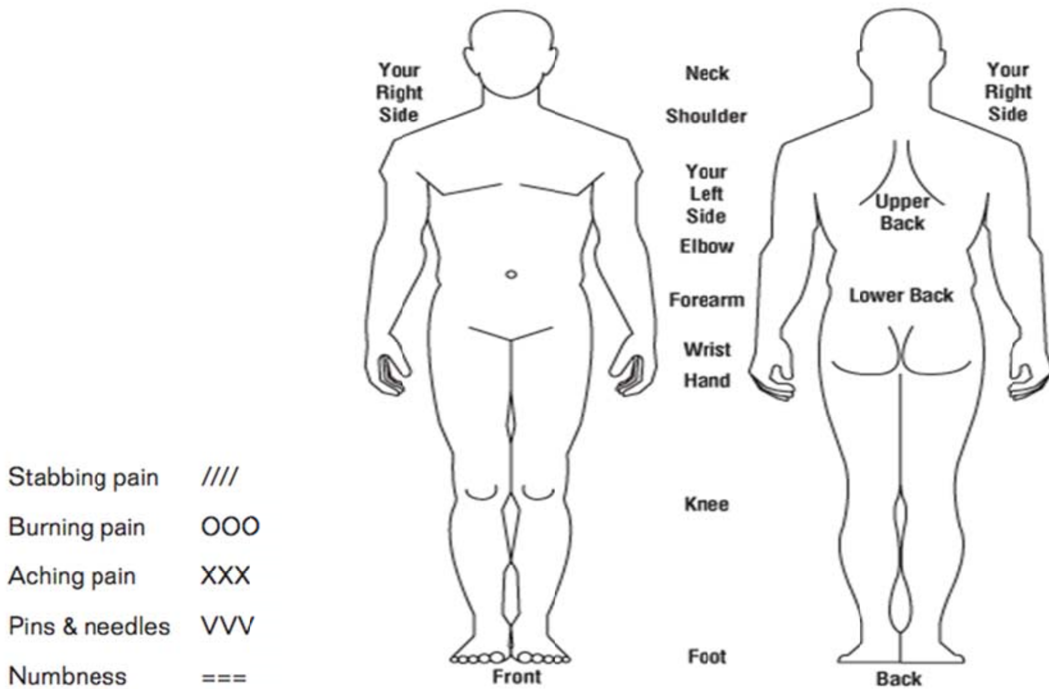
Gastrointestinal

Nausea	No Yes
Frequent diarrhea	No Yes
Constipation	No Yes
Blood in stool	No Yes

Respiratory

Frequent coughs	No Yes
Shortness of breath	No Yes
Wheezing	No Yes

Please mark the areas in the diagram where you feel pain:



Circle the number that describes the severity of your pain: **no pain 1 2 3 4 5 6 7 8 9 10 severe pain**

To the best of my knowledge, the questions of this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

____ ______________________
Signature of Patient or Parent of Minor Date

Reviewed by: ______________________________________ ______________________
Physician Signature Date