CALIFORNIA PACIFIC ORTHOPAEDICS

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PATIENT REGISTRATION FORM

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**

CALIFORNIA PACIFIC ORTHOPAEDICS

Patient Consent

By signing this consent form, you give California Pacific Orthopaedics permission to use and disclose protected health information about you for treatment, payment and healthcare operations (except for any restrictions specified in the Form to Request Restriction). Protected health information (PHI) is individually identifiable information we create or receive. It may include demographic information relating to your physical or mental health. Protected health information may be utilized for the provision of healthcare services to you and the collection of payment for services provided. HIPAA permits the use and disclosure of PHI for treatment, payment and healthcare operations (TPO).

With this consent, California Pacific Orthopaedics may call my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results amongst others.

With this consent I authorize California Pacific Orthopaedics to mail to my home or other alternative location any items that assist the practice in carrying out TPO (such as patient statements) as long as they are marked Personal and Confidential. In addition, I give California Pacific Orthopaedics permission to speak with the below people regarding billing issues, lab results, or any other information pertaining to my treatment and care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purpose of requesting your revocation or you may simply send us a letter in writing.

I have read and understand the policy as outlined above. I understand that if I do not sign this form California Pacific Orthopaedics has the right to refuse me treatment unless required by law.

_____

Signature of Patient/Legal Guardian Relationship

_____

Patient Name (Print) Today's Date

CALIFORNIA PACIFIC ORTHOPAEDICS

Office Policy and Patient Financial Agreement

I agree that in return for services provided to me by California Pacific Orthopaedics, I will pay my account at the time of service or will make financial arrangements satisfactory to California Pacific Orthopaedics. 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. I understand that if my account is delinquent, it may be turned over to a collection agency.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the practice does not participate are considered a self-pay account. It is the undersigned's responsibility to inform the practice of any insurance coverage changes, to confirm the practice's participation and to verify eligibility prior to each visit. I understand and agree that I am individually obligated to pay the full charges of all services rendered to me by CPO if I belong to a plan in which California Pacific Orthopaedics does not participate.

SELF-PAY ACCOUNTS

Self-pay accounts are for patients who are covered by carriers with which the practice does not participate or patients without verifiable insurance on file at the time of service. 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.

HMO REFERRALS & AUTHORIZATIONS

If your insurance has designated a primary care physician (PCP), you are requrired to have prior authorization from your PCP prior to your office visit. If the authorization is not provided, whether by yourself or through your insurance carrier, you will be asked to either rescheudle your appointment or pay for your visit at the time of service.

NON-COVERED SERVICES

I understand that California Pacific Orthopaedics contracts with health care service plans (i.e. HMOs, PPOs) that relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts 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. The patient is responsible for payment. If the primary care provider has not given clearence for the surgery, the surgery scheduling coordinator at California Pacific Orthopaedics 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. The patient is responsible for payment.

MISSED APPOINTMENTS

Failure to arrive for scheduled appointments and/or failure to cancel appointments 24 hours prior to the appointment time will result in a missed appointment fee of $75 for each occurance. The missed appointment fee cannot be billed to the insurance. The patient is responsible for payment.

CALIFORNIA PACIFIC ORTHOPAEDICS

Office Policy and Patient Financial Agreement

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. The patient is 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. The patient is responsible for payment.

REFUND REQUESTS

Payment 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 medical or other information necessary to determine benefits or the benefits payable for related equipment or services to California Pacific Orthopaedics, my insurance carrier or other medical entity. A copy of this authorization may be sent to my insurance company or other entity if requested. a copy will be kept on file at California Pacific Orthopaedics.

NOTICE OF PRIVACY PRACTICES

The misuse of personal health information (PHI) has been identified as a national problem. We want to assure our patients that all employees, managers and physicians continually undergo training in how to comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

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 the plan we have implemented a compliance program that oversees the prevention for any inappropriate use of PHI.

I have read and understand the policies as outlined above. I understand that by signing this form I am accepting financial responsibly as explained for payment for all products and services received. I understand my financial responsibility as a patient.

_____

Signature of Patient Date

_____

Signature of Legal Guardian Date/Relationship

_____

Patient Name (print) Date

CALIFORNIA PACIFIC ORTHOPAEDICS

ADULT SPINE HISTORY

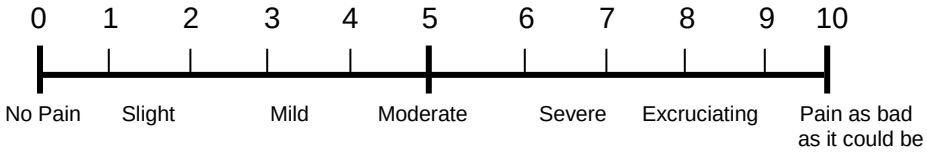
NAME: _____ **DATE:** _____

EMAIL: _____

1. Why are you seeing the doctor today: _____
2. How long has the pain/condition been present: _____
3. Has the pain/condition worsened recently:

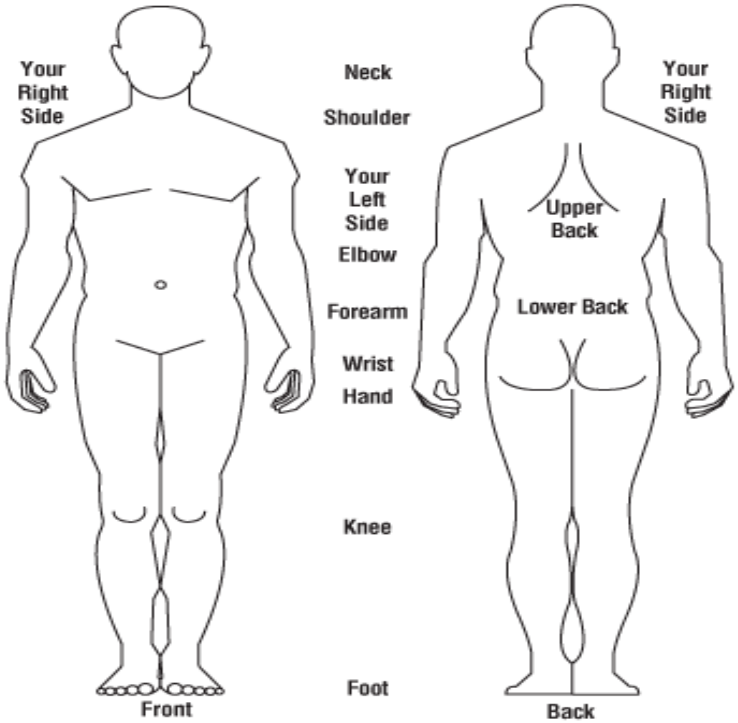
   ❑ No ❑ Yes, how recently: _____
4. What started the pain/condition: _____

IF THERE IS SPINAL PAIN PRESENT, HOW WOULD YOU RATE IT?



5. Quality of the Pain: ❑ Sharp ❑Burning ❑ Dull ❑ Aching ❑ Other: _____
6. Location of Pain/Condition:

Stabbing pain	////
Burning pain	OOO
Aching pain	XXX
Pins & needles	VVV
Numbness	===



How much of your pain is present in your Neck or Arm: Please give a percentage: (e.g. 50%)
Neck: _____ Arm and which side: _____

How much of your pain is present in your Back or Leg: Please give a percentage (e.g. 50%)
Back: _____ Leg and which side: _____

7. What makes the pain/condition better: _____
8. What makes the pain/condition worse: _____
9. Is the pain/condition:

   ❑ Continuous ❑ Activity Related ❑ Night Pain ❑ Other: _____
10. Did the pain start at work: _____
11. Have you filed a worker's compensation claim: _____
12. Have you ever lost bowel or bladder control: _____
13. Do you have trouble with fine motor movements/buttons/writing/balance: _____
14. Treatments have included: ❑ No medicines, therapy, manipulations, injections, or braces

Check all that apply:	**When?**
❑ Physical therapy, exercise	_____
❑ Anti-inflammatory medications	_____
❑ Massage & ultrasound	_____
❑ Narcotic medication	_____
❑ Traction	_____
❑ Manipulation	_____
❑ Tens Unit	_____
❑ Shoulder injections	_____
❑ Braces	_____
❑ Epidural steroid injections	_____
How many times _____, which relieved the pain for (how long)? _____	
❑ Trigger point injections	
How many times _____, which relieved the pain for (how long)? _____	
❑ Other _____	

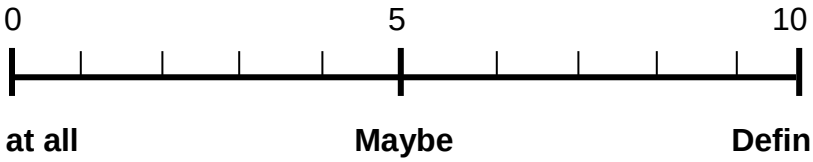
If you have seen other specialists or surgeons for this problem and were not happy, why?

- ❑ Didn't answer my questions
- ❑ Had no suggestions on what to do
- ❑ Personality issues
- ❑ Office staff problems
- ❑ Spent too little time with me
- ❑ Other _____

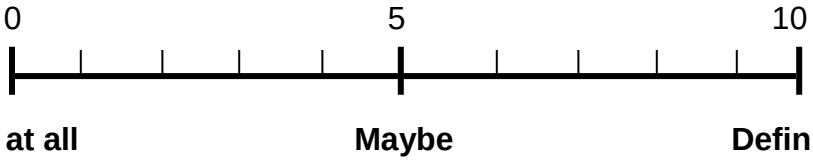
My main goal(s) today is (are) to get (check all that apply):

- ❑ Second opinion
- ❑ Recommendation for Physical Therapy
- ❑ Medications
- ❑ Injection treatments
- ❑ Surgery
- ❑ Other _____

If recommended, please rate how interested you are in having **SURGERY** to treat your problem:



If recommended, please rate how interested you are in having **INJECTIONS** to treat your problem:



Please take time to review the questionnaire for completeness. Your complete medical information is very important to us! Thank you!

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient/family:

Physician Signature:_____ Date: _____

CALIFORNIA PACIFIC ORTHOPAEDICS

COMPREHENSIVE HEALTH HISTORY
(PLEASE USE BLUE OR BLACK INK ONLY)

Name:_____ Today's Date:_____

Date of Birth:_____ Age: _____ Height:____ft ____in Weight:_____lbs

Primary Doctor Name and Address:

_____

_____

_____

_____

Preferred Pharmacy (Address/Phone):

_____

_____

_____

_____

PAST MEDICAL HISTORY: ***Check all that apply*** ❑ ***None Apply***

❑ Heart attack	❑ Asthma	❑ Rheumatoid arthritis	❑ Depression
❑ Heart failure	❑ Tuberculosis	❑ Osteoarthritis	❑ ADHD
❑ Abnormal heartbeat	❑ Emphysema	❑ Gout	❑ Seizures
❑ High blood pressure	❑ Thyroid	❑ Osteoporosis	❑ Migraine
❑ Stroke	❑ Stomach ulcers	❑ Cirrhosis	❑ Cerebral palsy
❑ Blood clots in leg	❑ Gastric reflux	❑ Hepatitis (A, B or C)	❑ Downs syndrome
❑ Blood clots in lung	❑ Hiatal hernia	❑ HIV/AIDS	❑ Spina bifida
❑ Poor circulation	❑ Kidney failure	❑ Bleeding disorder	❑ Neurofibromatosis
❑ High cholesterol	❑ Kidney stones	❑ Anemia	❑ MRSA

❑ Neuropathy: ❑ Hands or ❑ Feet

❑ Cancer: _____(type/treatment)

❑ Diabetes: year diagnosed _____

Currently controlled with ❑ insulin ❑ oral medications ❑ diet

❑ Other: _____

_____

PAST SURGICAL HISTORY: ❑ ***No Prior Surgery***

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? ❑ No ❑ Yes
If YES, have you had any problems related to this? ❑ No ❑ Yes

Please explain any problems related to general anesthesia: _____

_____

MEDICATIONS (prescribed and over the counter): ❑ ***I take no medications***

Name of Medication	Dose	Reason

ALLERGIES TO MEDICATIONS: ❑ ***No Allergies***

Name of Medication	Reaction (rash, swelling, stomach upset, etc.)

METAL ALLERGIES: ❑ ***No Allergies*** ❑ Yes_____ (List Metals)

SOCIAL HISTORY:
Work status:

❑ Working ❑ Homemaker ❑ Unemployed ❑ Disabled ❑ Retired ❑ Student

Occupation_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Children: ❑ No ❑ Yes, How Many? _____

Do you live alone?____ If no, who lives with you?_____

Are you currently smoking? ____ If yes, how many packs a day? ____ For how many years? _____

Have you quit smoking? If so, when did you quit? _____ How many years did you smoke?_____

How many packs a day did you previously smoke?_____Other forms of tobacco?_____

Alcohol Use ❑ Never ❑ Rare ❑ Social ❑ Frequently (more than twice a week)
❑ Alcoholic ❑ Recovering Alcoholic

Illegal Drug Use ❑ Never ❑ In the past ❑ Currently Types of Drugs_____

FAMILY HISTORY: ❑ ***None***

Mother: _____

Father: _____

Siblings: _____

REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)

❑ Fever	❑ Sleep apnea (snoring)	❑ Nausea
❑ Chills	❑ Hoarseness	❑ Vomiting
❑ Weight loss	❑ Cough	❑ Diarrhea
❑ Weight gain	❑ Trouble swallowing	❑ Constipation
❑ Vision changes	❑ ***Chest pain***	❑ Hemorrhoids
❑ Glasses/Contacts	❑ ***Palpitations***	❑ Stomach pain
❑ Hearing loss	❑ Swollen ankles	❑ Urinary difficulty
❑ Dizziness	❑ ***Shortness of breath***	❑ Anxiety
❑ Ear pain	❑ Seasonal allergies	❑ Hyperactivity
❑ Nosebleeds	❑ Skin rashes	❑ Memory loss
❑ Toothache	❑ Swollen glands	❑ Blackouts
❑ Gum problems	❑ Poor appetite	❑ Headache

❑ ***I have not experienced any of the above symptoms in the last 30 days***

❑ Other:_____

_____

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient/family:

Physician Signature:_____ Date: _____