



### Patient Registration Form

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#### PATIENT INFORMATION

Last Name:		First Name:		Middle Initial:	Date of Birth: / /
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name? (Former name):			Age:
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Decline		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other <input type="checkbox"/> Decline <input type="checkbox"/> Transgender - <input type="checkbox"/> Female <input type="checkbox"/> Male		Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Separated	
Race:		Ethnicity:		Social Security #	Phone: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work ( )
Street Address:				P.O. Box:	
City:			State:		ZIP Code:
Occupation:		Employer:		Employer Phone #: ( )	
How did you hear about us? <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Social Media _____					
<input type="checkbox"/> Website <input type="checkbox"/> Advertisement <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Hospital <input type="checkbox"/> Other					
Patient's E-mail Address:				Appointment Reminder: <input type="checkbox"/> Text Message <input type="checkbox"/> Phone call	

Referring Physician : \_\_\_\_\_ Tel #: \_\_\_\_\_

Primary Care Physician (if different from above): \_\_\_\_\_ Tel:# \_\_\_\_\_

#### IN CASE OF EMERGENCY

Name:	Relationship to patient:	Contact Phone #: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work ( )	Contact Phone #: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work ( )
Name:	Relationship to patient:	Contact Phone #: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work ( )	Contact Phone #: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work ( )

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 also authorize CALIFORNIA PACIFIC ORTHOPAEDICS or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

**WORKERS COMPENSATION ONLY**

Date of Injury:	Claim #:	Workers Compensation Insurance Carrier:
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Carrier Address:	City:	State:	Zip Code:
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Claims Adjuster:	Phone #: (    )	Fax#: (    )
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Attorney:	Phone #: (    )	Fax#: (    )
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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?:



## 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.

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Signature of Patient/Legal Guardian

Relationship

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Patient Name (Print)

Today's Date





## **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 required 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 reschedule 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 services, 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 clearance 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 occurrence. The missed appointment fee cannot be billed to the insurance. The patient is responsible for payment.



## 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. We are part of a shared EHR with UCSF and your records created are (i) integrated in the UC Host's EHR, (ii) will be accessible by UC Host and/or its affiliates, and (iii) may be used by UC Host for quality and research purposes in accordance with the law. 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.

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Signature of Patient

Date

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Signature of Legal Guardian

Date/Relationship

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Patient Name (print)

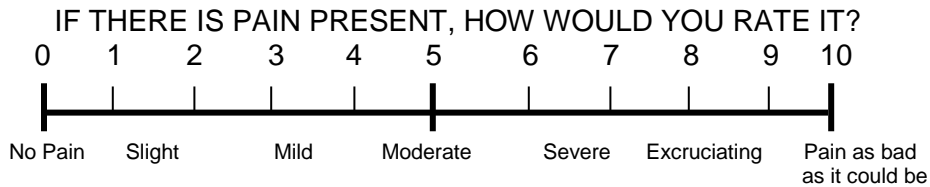
Date

## 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: \_\_\_\_\_



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

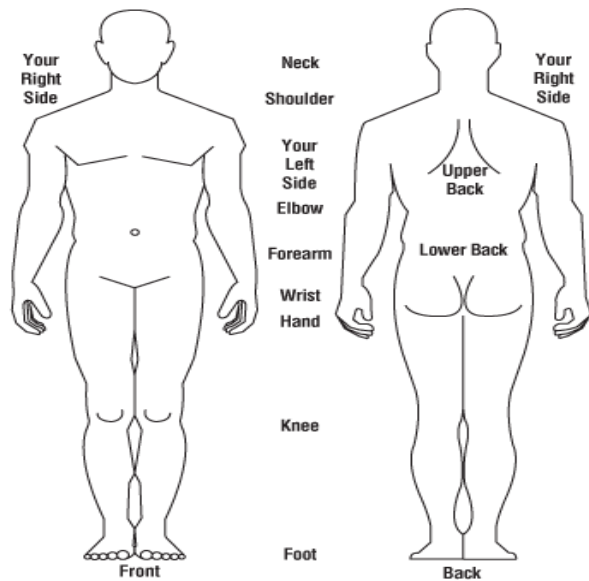
Stabbing pain    ///

Burning pain    OOO

Aching pain     XXX

Pins & needles  VVV

Numbness        ===



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. Have you ever lost bowel or bladder control: \_\_\_\_\_

11. Do you have trouble with fine motor movements/buttons/writing/balance: \_\_\_\_\_

12. Treatments have included:  I have received no treatments.

**Check all that apply:**

**When?**

- Physical therapy, exercise \_\_\_\_\_
- Anti-inflammatory medications \_\_\_\_\_
- Massage & ultrasound \_\_\_\_\_
- Narcotic medication \_\_\_\_\_
- Traction \_\_\_\_\_
- Manipulation \_\_\_\_\_
- Tens Unit \_\_\_\_\_
- 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 \_\_\_\_\_

13. Have you had spinal surgery? If so, please provide details and date of surgery.

\_\_\_\_\_

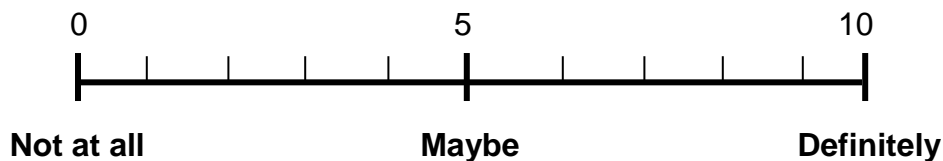
14. If you have seen other specialists or surgeons for this problem and were not happy, why?

- Didn't answer my questions
- Had no suggestions on what to do
- Other \_\_\_\_\_

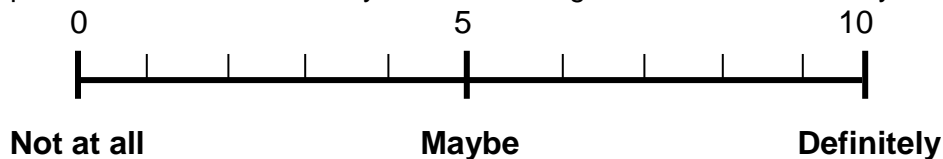
15. My main goal(s) today is (are) to get (check all that apply):

- 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!**





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

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs

Primary Doctor (Name & 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: \_\_\_\_\_

**NON-SPINE SURGICAL HISTORY:  No Prior Surgery**

Operation	Date	Surgeon/Hospital

**WORK STATUS:**

- Working     Homemaker     Unemployed     Disabled     Retired     Student

Occupation: \_\_\_\_\_

**SOCIAL HISTORY:**

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 (twice a week or more)  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  Chest pain  Cough  Swollen ankles
- Chills  Palpitation  Constipation  Dizziness
- Diarrhea  Shortness of breath  Stomach pain  Blackouts
- Nausea  Headache  Urinary difficulty  Sleep apnea (snoring)
- Vomiting  Hearing loss  Ear pain  Hoarseness
- Trouble swallowing  Memory loss  Hyperactivity  Vision changes

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

Other: \_\_\_\_\_

**ALLERGIES TO MEDICATIONS:**  No Allergies

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

**METAL ALLERGIES:**  No Allergies  Yes \_\_\_\_\_ (List Metals)

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

Name of Medication	Dose	Reason

**FOR OFFICE USE ONLY**

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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_