Patient Registration Form

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PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Date of Birth: / /
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? (Former name):		Age:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ He/Him/His ❑ She/Her/Hers ❑ They/Them/Theirs ❑ Decline	Sex: ❑ Male ❑ Female ❑ Non-Binary ❑ Other ❑ Decline ❑ Transgender - □ Female □ Male	Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widow ❑ Separated	Social Security #	Phone: ❑ Home ❑ Mobile ❑ Work ( )

Race:	Ethnicity:	Language:

Street Address:	P.O. Box:

City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone #: ( )

How did you hear about us? ❑ Dr. ______________________________ ❑ Social Media ______________________________

❑ Website ❑ Advertisement ❑ Insurance Plan ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Hospital ❑ Other

Patient's E-mail Address:	**Appointment Reminder:** ❑ Text Message ❑ Phone call

Referring Physician : ____Tel #: ______________________

Primary Care Physician (if different from above):______________________________________ Tel:#______________________

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Contact Phone #: ❑ Home ❑ Mobile ❑ Work ( )	Contact Phone #: ❑ Home ❑ Mobile ❑ Work ( )
Name:	Relationship to patient:	Contact Phone #: ❑ Home ❑ Mobile ❑ Work ( )	Contact Phone #: ❑ Home ❑ Mobile ❑ 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:	
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?:			

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

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.

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.

____
Signature of Patient Date

____
Signature of Legal Guardian Date/Relationship

____
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: ____

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

0 1 2 3 4 5 6 7 8 9 10

No Pain | Slight | Mild | Moderate | Severe | Excruciating | Pain as bad as it could be

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	===

Your Right Side
Neck
Shoulder
Your Left Side
Elbow
Forearm
Wrist
Hand
Knee
Foot
Front
Your Right Side
Upper Back
Lower Back
Back

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:

0 5 10

|—|—|—|—|—|—|—|—|—|—|

Not at all **Maybe** **Definitely**

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

0 5 10

|—|—|—|—|—|—|—|—|—|—|

Not at all **Maybe** **Definitely**

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

Use of Alcohol ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Use of Tobacco ❑ Never ❑ Previously, but quit ❑ Currently Amount per day______

Use of Smokeless Tobacco ❑ Never ❑ Previously, but quit ❑ Currently Amount per day_____

Living Situation ❑ With spouse ❑ With children (how many ___) ❑ Alone ❑ Other ___________

Falls – Have you fallen within the last year? If yes, did the fall result in injury? ❑ No ❑ Yes, with no injury ❑ Yes, with injury

Flu Immunization this calendar year? ❑ Yes ❑ No

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: ________________________