CALIFORNIA PACIFIC ORTHOPAEDICS

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?:			

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. 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

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

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
_____		_____	
_____		_____	
_____		_____	

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

Father: _____

Mother: _____

Siblings: _____

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, no injury ❑ Yes, with injury

Flu Immunization this calendar year? ❑ Yes ❑ No

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

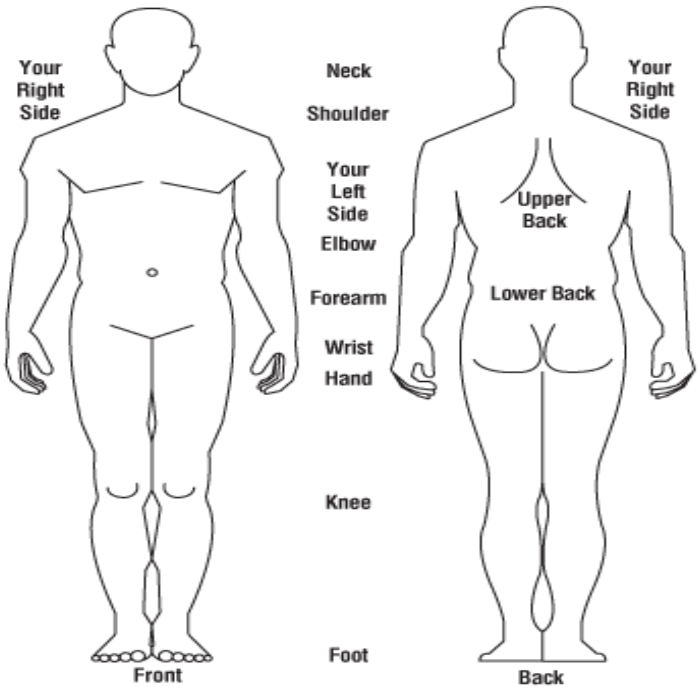
Gastrointestinal

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:



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

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