



Patient Registration Form

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PATIENT INFORMATION

Form containing patient information fields: Last Name, First, Middle Initial, Marital status, Birthdate, Age, Sex, Race, Ethnicity, Language, Street Address, Social Security #, Contact Phone #, P.O. Box, City, State, ZIP Code, Occupation, Employer, Employer Phone #, How did you hear about us?, Patient's e-mail address, Referring Physician, Primary Care Physician.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Form containing insurance information fields: Insurance guarantor, Birthdate, Address, Contact Phone #, Primary insurance name, Secondary insurance name, Subscriber's name, Birthdate, Patient's relationship to subscriber.

IN CASE OF EMERGENCY

Form containing emergency contact fields: Name, Relationship to patient, Home phone #, Work phone #.

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 & SPORTS MEDICINE 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?:				

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



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 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. 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 responsibility 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

PATIENT MEDICAL HISTORY

Today's Date: _____

MRN: _____

Patient Name: _____ Birth Date: _____ Male FemaleDate of Injury: _____ Work-related Auto accident injury I am right-handed left-handed

Occupation: _____ Primary Care Physician: _____ Referring Physician: _____

HISTORY OF PRESENT ILLNESSHeight: _____ 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 YesPhysical therapy No Yes If yes, did it help No YesSteroid injections No Yes If yes, did it help No YesHave 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:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Metal in Body | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> 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):

<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>
_____			_____		
_____			_____		
_____			_____		

Past surgical/hospitalization history:

<u>Year</u>	<u>Surgery/Illness</u>	<u>Year</u>	<u>Surgery/Illness</u>
_____		_____	
_____		_____	
_____		_____	

<u>Patient Social History:</u>	<u>Marital Status</u>	<u>Use of Alcohol</u>	<u>Use of Tobacco</u>	<u>Living Situation</u>
	<input type="checkbox"/> Single	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> With spouse
	<input type="checkbox"/> Married	<input type="checkbox"/> Rarely	<input type="checkbox"/> Previously, but quit	<input type="checkbox"/> With children (how many ___)
	<input type="checkbox"/> Divorced	<input type="checkbox"/> Moderate	<input type="checkbox"/> Currently	<input type="checkbox"/> Alone
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Daily	Amount per day ___	<input type="checkbox"/> Other _____
	<input type="checkbox"/> 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 than current pain) No Yes
 Weakness of muscles or joints No Yes
 Back pain No Yes
 Difficulty in walking No Yes

Genitourinary

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

Hematologic / Lymphatic

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

Constitutional Symptoms

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

Female History

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

Psychiatric

Memory loss No Yes
 Anxiety No Yes
 Depression No Yes
 Insomnia 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

Skin

Rash No Yes
 Varicose veins No Yes
 Skin disease No Yes

Gastrointestinal

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

Cardiovascular

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

Neurological

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

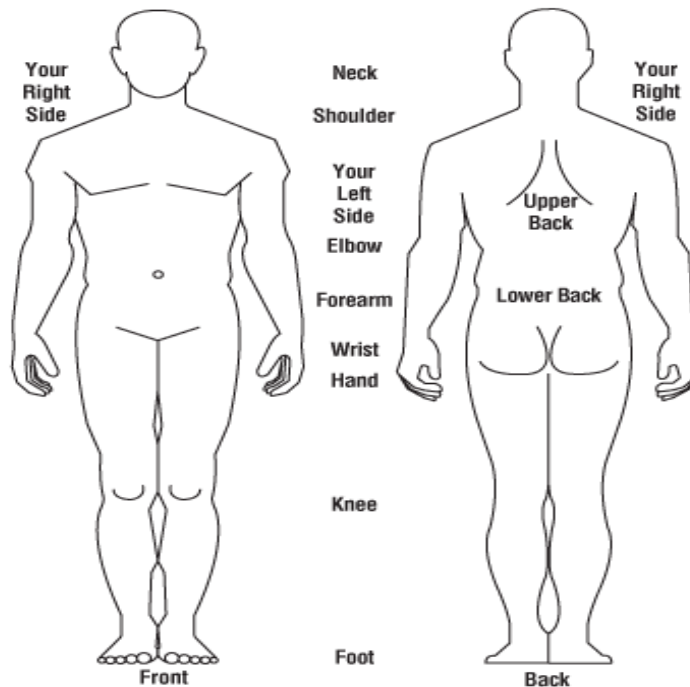
Respiratory

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

Endocrine

Excessive thirst No Yes
 Heat or cold intolerance 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 _____