CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE
PATIENT REGISTRATION FORM

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(Please Print)

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ 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 #:	Home Phone #: ( )				
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer Phone #: ( )				

How did you hear of CPOSM? ❑ Website ❑ Dr._____ ❑ Advertisement _____ ❑ Insurance Plan
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other_____ ❑ Hospital

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):	Home Phone #: ( )		
Occupation:	Employer:	Employer Address:	Employer Phone #: ( )		
Please indicate primary insurance					
Is this patient covered by insurance? ❑ Yes ❑ No					
Subscriber's name:	Subscriber's S.S.#:	Birthdate: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY

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***

CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE
PATIENT MEDICAL HISTORY

Today's Date: _____ MRN: _____

Patient Name: _____ Birth Date: _____ ❑ **Male** ❑ **Female**

Date of Injury:_____ ❑ Work-related ❑ Auto accident injury **Are you? ❑ Right-handed ❑ Left-handed**

Occupation:_____ Primary Care Physician:_____

Referred by: _____

HISTORY OF PRESENT ILLNESS:

Height: _____' _____" **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? _____

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please check all that apply:*

❑ 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.

_____ _____ _____ **Latex Allergy** ❑ No ❑ Yes

_____ _____ _____ **Egg/Chicken 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

PATIENT SOCIAL HISTORY:

Marital Status
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed
- ❑ Separated

Use of Alcohol
- ❑ Never
- ❑ Rarely
- ❑ Moderate
- ❑ Daily

Use of Tobacco
- ❑ Never
- ❑ Previously, but quit
- ❑ Currently

_____ packs per day

Living Situation
- ❑ With Spouse
- ❑ With Children (How many?) ____
- ❑ Alone
- ❑ Other _____

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: (Please 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

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**

California Pacific Orthopaedics & Sports Medicine
Patient Consent

By signing this consent form, you give California Pacific Orthopaedics & Sports Medicine (CPOSM) 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, CPOSM 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 CPOSM 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 CPOSM 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, CPOSM 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 & Sports Medicine
Office Policy and Patient Financial Agreement

I agree that in return for services provided to me by California Pacific Orthopaedics & Sports Medicine (CPOSM), I will pay my account at the time of service or will make financial arrangements satisfactory to CPOSM. 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 CPOSM. 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 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 CPOSM if I belong to a plan in which CPOSM 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 CPOSM 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 CPOSM 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 within 24 hours of 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.

California Pacific Orthopaedics & Sports Medicine
Office Policy and Patient Financial Agreement

MEDICAL RECORD REQUESTS
An advance payment is required for copies of medical records, X-ray and/or MRI reports. The fee may vary depending on medical record needs. This cannot be charged 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 fee cannot be billed to insurance. The patient is responsible for payment.

REFUND REQUESTS
Patient overpayments will be refunded within 30 days of CPOSM's 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 CPOSM, 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 CPOSM.

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