



ROSEVILLE ORTHOPEDIC
SURGERY AND SPORTS MEDICINE

NEW PATIENT REGISTRATION

PLEASE PRINT

Date _____

Patient _____
Last Name First Name Middle Initial

Birthdate _____ Age _____ Male _____ Female _____ Home Phone _____

Address _____ Cell Phone _____

City _____ County _____ State _____ Zip _____

Marital Status _____ Married _____ Single _____ Divorced _____ Widowed _____ Social Security# _____

Driver's License # _____ Email Address _____

Patient Employed By _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Emergency Contact _____ Relationship _____ Phone Number _____

Date of Injury or Onset: _____ How did Injury occur? _____

Did you bring x-rays with you? _____ Where were they taken? _____

Responsible Party (if different from above) _____ Relationship _____

Address _____ Birthdate _____

City _____ State _____ Zip _____ Home Phone _____

Social Security # _____ Driver's License # _____

Employer _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Spouse or Other Parent/Guardian Information (Please circle one)

Name _____ Home Phone _____

Employer _____ Business Phone _____

PAYMENT: All charges are due at the time of services, all professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.

WORKER'S COMP? YES NO MOTOR VEHICLE ACCIDENT? YES NO LITIGATION PENDING? YES NO

Insurance Information (Please present insurance cards to front desk)

Name of Insurance Company _____ Policy Holder's Name _____

Policy Holder's DOB _____ Employer _____

Billing Address _____

Policy Number _____ Group Number _____

Name of Secondary Insurance _____ Policy Holder _____ DOB _____

Billing Address _____ Employer _____

Policy Number _____ Group Number _____

Worker's Comp Carrier _____ Claim Number _____

Date of Injury _____ Adjuster's Name _____ Phone Number _____

Referring Physician or Person _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Family Physician _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Our medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

Financial Agreement

We thank you for choosing our group for your orthopedic treatment. Any pain can cause an inconvenience in your life. This can be stressful, and so can the financial responsibility of health care. By working together on the physical pain relief and the financial piece, we can relieve some stress and move toward a healthier life overall. Below is our financial policy:

We normally bill for your services to your insurance plan. If this is not approved in advance, your payment will be due at the time of service by check, cash, Visa or MasterCard.

We are on the list of panel providers for most major insurance carriers. You are responsible for any of the following as required by your plan: a referral, co-pay and coinsurance or deductible; all to be paid at the time of service.

You are responsible for any balance not covered by insurance (examples: denied services, or services not covered by your plan). If this is not paid timely, we have a collection service that will take over your account. This additional service costs more money, for both of us, your portion is approx \$20.00. We require payment when due to keep everyone's expenses to a minimum.

If you need surgery, we advise you to know and understand your insurance coverage. We will pre-approve the surgery with your carrier, however, it is not a guarantee the services will be fully paid. We may require you to pay a deposit, deductible or co-pay prior to surgery.

Our staff is highly trained and here to discuss your responsibilities for payment of services, if you have any questions. Another good source for you is your insurance customer service representative.

Please sign below to indicate that you have read, understand and agree with the above statements.

Patient/Parent Signature _____ **Date** _____

Medicare Patient Signature Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, or billing agent of this physician or supplier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made either to me or Roseville Orthopedic Surgery & Sports Medicine on any bills for services furnished me by that physician.

Patient Signature _____ **Date** _____

Assignment of Benefits

I hereby authorize that payment of the amount due me in my pending insurance claim be made directly to: Roseville Orthopedic Surgery & Sports Medicine. Payment is authorized upon your receipt of an itemized statement of services.

Patient Signature _____ **Date** _____

Records Release Authorization

I hereby authorize Roseville Orthopedic Surgery & Sports Medicine to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records of treatment, concerning my medical history and orthopedic care.

Patient Signature _____ **Date** _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below. I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

| | | | |
|-----------------|---------------|--------------------------------------|------|
| Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian | Date |
|-----------------|---------------|--------------------------------------|------|

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care in that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Phone #: _____
Print Name: _____ Phone #: _____
Print Name: _____ Phone #: _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

 OK to leave message with detailed information
 Leave message with call back numbers only

Work Telephone Number:

 OK to leave message with detailed information
 Leave message with call back numbers only

Written Communication Address:

 OK to mail to address listed above
 E-mail me at _____

Fax Communication:

 OK to fax at the number listed above
 E-mail me at _____

Other: _____

| | | |
|-------------------------|-----------|------|
| Name of Patient (Print) | Signature | Date |
|-------------------------|-----------|------|



ROSEVILLE ORTHOPEDIC
SURGERY AND SPORTS MEDICINE

Medical Information

Primary Care Physician: _____ Ph# _____

How were you referred to our office: _____

Reason for visit: _____ Date of Onset: _____

How did injury occur? _____

What treatment have you received? _____

What makes your symptoms worse, better? _____

Past Medical History:

Do you have any active medical problems? Please circle or list if not present
 Hypertension Diabetes High Cholesterol Hypothyroidism Rheumatoid Arthritis
 Other _____

What surgeries have you had in the past and when? _____

Are you allergic to anything, including medications? Please list and note reaction: _____

What medications do you take? _____

Have you had problems with anesthesia? _____

Social History: Are you married/single?

What type of work do you do? _____

Do you smoke? Y/N If so, how much _____

Family History: Please check in appropriate location if a family member has or has had any of the following:

| | Mother | Father | Sibling | Other (specify) |
|--------------------------|--------|--------|---------|-----------------|
| Heart Attack | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ |
| Rheumatoid Arthritis | _____ | _____ | _____ | _____ |
| Bleeding Disorder | _____ | _____ | _____ | _____ |
| Problems with anesthesia | _____ | _____ | _____ | _____ |

REVIEW OF SYSTEMS

Yes (Now or within last 6 months) or No. Please explain any yes answers in the space provided at the end of the form.

SYSTEM

GENERAL

Unwanted weight loss **Yes No**
 Fevers **Yes No**
 Chills **Yes No**
 Night Sweats **Yes No**

SYSTEM

EYES

Recent visual changes **Yes No**
 Pain in eyes **Yes No**
 Dryness **Yes No**
 Light intolerance **Yes No**



ROSEVILLE ORTHOPEDIC
SURGERY AND SPORTS MEDICINE

EARS, NOSE, THROAT

Hearing loss **Yes No**
 Ringing **Yes No**
 Frequent nose bleed **Yes No**
 Sore throat **Yes No**
 Hoarseness **Yes No**

CARDIOVASCULAR

Irregular heart beat **Yes No**
 Chest pain **Yes No**
 Swollen ankles **Yes No**
 Short of breath when
 lying down **Yes No**
 Passing out **Yes No**

RESPIRATORY

Cough yellow or green **Yes No**
 Sputum
 Cough up blood **Yes No**
 Shortness of breath **Yes No**
 Pain with breathing **Yes No**

GASTROINTESTINAL

Vomit blood **Yes No**
 Blood in stool **Yes No**
 Black stools **Yes No**
 Frequent nausea **Yes No**
 Loss of appetite **Yes No**
 Diarrhea **Yes No**

GENITOURINARY

Pain on urination **Yes No**
 Blood in urine **Yes No**
 Urinating too often **Yes No**
 Incontinence **Yes No**

SKIN

Rashes **Yes No**
 Non healing wounds **Yes No**
 Boils **Yes No**
 Dry skin **Yes No**

NEUROLOGIC

Seizures **Yes No**
 Fainting **Yes No**
 Dizziness **Yes No**
 Loss of coordination **Yes No**
 Weakness **Yes No**
 Numbness **Yes No**
 Tingling **Yes No**

PSYCHIATRIC

Depression **Yes No**
 Anxiety **Yes No**
 High stress level **Yes No**
 Mood swings **Yes No**
 Poor concentration **Yes No**

MUSCULOSKELETAL

Joint stiffness **Yes No**
 Joint pain **Yes No**
 Bone pain **Yes No**
 Multiple broken bones **Yes No**
 Weakness **Yes No**
 Joint swelling **Yes No**

ENDOCRINE

Excessive thirst **Yes No**
 Fatigue **Yes No**
 Feel too hot **Yes No**
 Feel too cold **Yes No**
 Dry skin **Yes No**
 Slow wound healing **Yes No**

HEMATOLOGIC/LYMPHATIC

Easy bruising **Yes No**
 Easy or prolonged bleeding **Yes No**
 Swollen glands **Yes No**
 Swelling in limbs **Yes No**
 Blood clots **Yes No**

ALLERGIC/IMMUNOLOGIC

Frequent infections **Yes No**
 Chronic infections **Yes No**
 Slow wound healing **Yes No**
 Frequent sneezing **Yes No**
 Chronic runny nose **Yes No**

Please explain any "yes" answers here:
