



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
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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
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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 certain of 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: _____

Print Name: _____

Print Name: _____

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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

Witness _____ Date _____

Patient name: _____

Date: _____

Age: _____ Date of Birth: _____

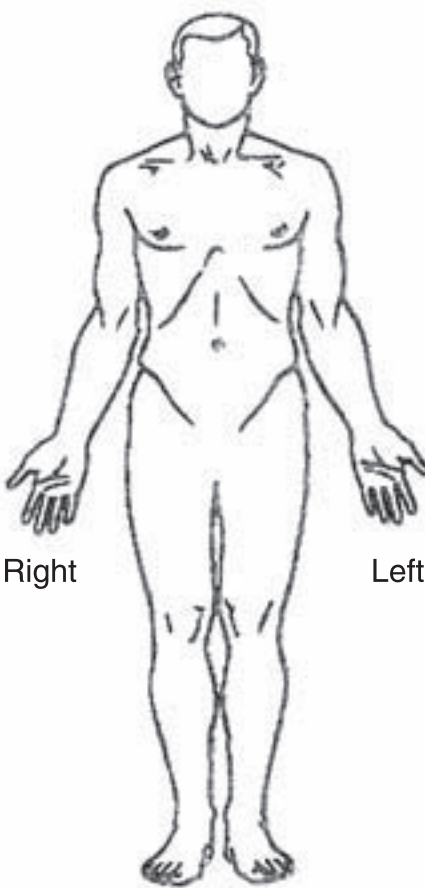
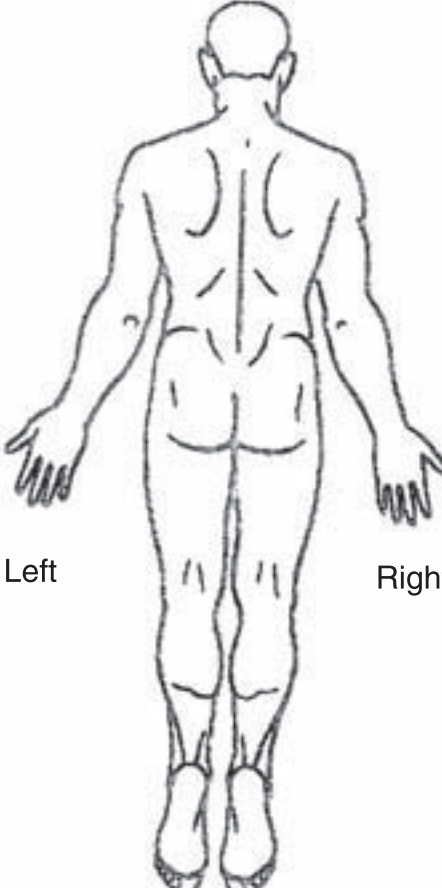
Primary Care Physician: _____

Referring Physician: _____

Spine Surgery New Patient Questionnaire

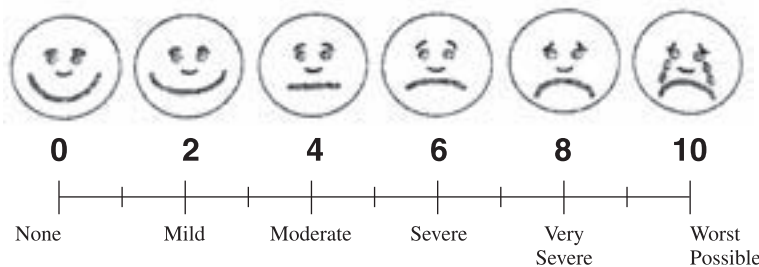
WHERE IS YOUR PAIN NOW?

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

<p>Front</p>  <p style="text-align: center;">Right Left</p>	<p>Ache ^^^^^ ^^^^^ ^^^^^</p> <p>Numbness OOOO OOOO OOOO</p> <p>Pins & Needles ===== ===== =====</p> <p>Burning XXXX XXXX XXXX</p> <p>Stabbing ///// ///// /////</p>	<p>Back</p>  <p style="text-align: center;">Left Right</p>
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Grade your overall Pain

Please place an **X** on the hash mark that most accurately describes your overall degree of pain now.



CURRENT HISTORY

What is the main reason for your visit today? (Check all that apply)

- Back Pain Leg Pain Neck Pain Arm Pain
 Other: _____

How long has this been a problem?

_____ Days _____ Weeks _____ Months _____ Year _____ Date of onset (if known) _____
 Further Comments: _____

Have you been treated by any other Care Giver for this condition? Yes No

If yes, please list: _____

Current problem is the result of a(n): (Check all that apply)

- Injured at work Auto Accident Sports No apparent cause
 Other: _____

Current problem began: (Check all that apply)

- Suddenly Gradually Lifting Twisting Fall
 Bending Pulling Other: _____

How long can you stand?

- Not at all Less than 10 minutes 10-30 minutes More than 30 minutes Indefinitely

How long can you walk?

- Not at all Less than 10 minutes 10-30 minutes More than 30 minutes Indefinitely

How long can you sit?

- Not at all Less than 10 minutes 10-30 minutes More than 30 minutes Indefinitely

Duration of *current* symptoms: _____ Weeks _____ Months _____ Years

Date of initial onset (if known): _____

Is there numbness and/or tingling associated with the pain: Yes No

Is there weakness in the affected leg or foot: Yes No

Have you noticed bowel or bladder problems (e.g. incontinence): Yes No

What have you tried for your symptoms thus far:

- Physical Therapy Traction Exercise
 Acupuncture Chiropractic TENS unit
 Injections Medications Other: _____

Indicate which activities WORSEN your symptoms:

- Sitting Standing Walking
 Lying down Bending forward Bending backward

Indicate which activities IMPROVE your symptoms:

- Sitting Standing Walking
 Lying down Bending forward Bending backward

Is your pain worse:

- In the morning Mid-day In the evening Other: _____

Is your pain better:

- In the morning Mid-day In the evening Other: _____

Which studies of your neck or back, if any, have you had in the last 2 years:

- Regular X-rays Bending X-rays MRI CT Scan
 Myelogram EMG Discogram CT Myelogram

Have you ever had neck or back surgery before: Yes No

Please list ALL prior surgeries (Spine AND Non-Spine) with dates (Month/Year):

MEDICAL HISTORY

Do you have a history of:

Blood clots/excessive-bleeding	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hypertension	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Adverse Reaction to Anesthesia	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cardiac Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Mental Health Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Other diagnosis: _____

MEDICATION ALLERGIES

Are you allergic to any medications? Yes No

If yes, list the medications

MEDICATION AND DOSAGE

Medication	Strength	# of pills per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

If you brought a list, please attach.

SOCIAL HISTORY

Do you smoke or use Tobacco products: Yes No

If yes, for how long: _____

Packs smoked per day: <1/2 1/2 1 2 3 4

Have you quit smoking? Yes No If yes when? _____

Do you drink Alcohol: Yes No

If yes, drinks per day: <1 1 2 3 4 5 >5

Do you use any other Drugs: Yes No If yes, which drugs: _____

Are you on Disability: Yes No If yes, Date started: _____

Is there a lawsuit associate with this injury: Yes No

Is this a workman's compensation claim: Yes No

If yes, When was the date of injury: _____

BRIEFLY describe the mechanism of injury: _____

Are you currently: Employed Unemployed Student Retired

If employed, what is your occupation: _____

Are you presently working: Yes No

If no, what is the last date worked: _____

Are you: Married/Partnered Single Divorced/Separated Widowed

Number of Children, if any: _____

FAMILY HISTORY

List any blood relatives with a history of:

<input type="checkbox"/> Blood clots / excessive bleeding	Relationship _____
<input type="checkbox"/> Adverse reaction to anesthesia	Relationship _____
<input type="checkbox"/> Cardiac disorders	Relationship _____
<input type="checkbox"/> Cancer	Relationship _____
<input type="checkbox"/> Diabetes	Relationship _____
<input type="checkbox"/> Auto immune disorders	Relationship _____

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

Please describe all yes answers

Skin	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Ears, Nose, Throat	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Cardiac/High blood pressure	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Lungs, (Asthma, Infection)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Stomach/Digestion	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Bladder/Bowel problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Hematologic/Bleeding problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Musculoskeletal	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Neurological	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Psychiatric problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Reproductive/Sexual Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Fever/Chills	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Night Sweat	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Night Pain	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Unexpected Weight Loss	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____

Patient Signature: _____

Date: _____

OSWESTRY DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

<p>SECTION 1 - Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment</p> <p><input type="checkbox"/> The pain is very mild at the moment</p> <p><input type="checkbox"/> The pain is moderate at the moment</p> <p><input type="checkbox"/> The pain is fairly severe at the moment</p> <p><input type="checkbox"/> The pain is very severe at the moment</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment</p>	<p>SECTION 6 - Standing</p> <p><input type="checkbox"/> I can stand as long as I want without extra pain</p> <p><input type="checkbox"/> I can stand as long as I want but it gives me extra pain</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 1 hour</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 30 minutes</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes</p> <p><input type="checkbox"/> Pain prevents me from standing at all</p>
<p>SECTION 2 - Personal Care (Washing, Dressing, etc.)</p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful</p> <p><input type="checkbox"/> I need some help, but manage most of my personal care</p> <p><input type="checkbox"/> I need help every day in most aspects of self care</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed</p>	<p>SECTION 7 - Sleeping</p> <p><input type="checkbox"/> My sleep is never disturbed by pain</p> <p><input type="checkbox"/> My sleep is occasionally disturbed by pain</p> <p><input type="checkbox"/> Because of pain I have less than 6 hours sleep</p> <p><input type="checkbox"/> Because of pain I have less than 4 hours sleep</p> <p><input type="checkbox"/> Because of pain I have less than 2 hours sleep</p> <p><input type="checkbox"/> Pain prevents me from sleeping at all</p>
<p>SECTION 3 - Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives extra pain</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned</p> <p><input type="checkbox"/> I can lift very light weights</p> <p><input type="checkbox"/> I cannot lift or carry anything at all</p>	<p>SECTION 8 - Sex Life (If applicable)</p> <p><input type="checkbox"/> My sex life is normal and causes no extra pain</p> <p><input type="checkbox"/> My sex life is normal but causes some extra pain</p> <p><input type="checkbox"/> My sex life is nearly normal but is very painful</p> <p><input type="checkbox"/> My sex life is severely restricted by pain</p> <p><input type="checkbox"/> My sex life is nearly absent because of pain</p> <p><input type="checkbox"/> Pain prevents any sex life at all</p>
<p>SECTION 4 - Walking</p> <p><input type="checkbox"/> Pain does not prevent me walking any distance</p> <p><input type="checkbox"/> Pain prevents me from walking more than 1 mile</p> <p><input type="checkbox"/> Pain prevents me from walking more than ½ mile</p> <p><input type="checkbox"/> Pain prevents me from walking more than 100 yards</p> <p><input type="checkbox"/> I can only walk using a stick or crutches</p> <p><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet</p>	<p>SECTION 9 - Social Life</p> <p><input type="checkbox"/> My social life is normal and gives me no extra pain</p> <p><input type="checkbox"/> My social life is normal but increases the degree of pain</p> <p><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport</p> <p><input type="checkbox"/> Pain has restricted my social life and I do not go out as often</p> <p><input type="checkbox"/> Pain has restricted my social life to my home</p> <p><input type="checkbox"/> I have no social life because of pain</p>
<p>SECTION 5 - Sitting</p> <p><input type="checkbox"/> I can sit in any chair as long as I like</p> <p><input type="checkbox"/> I can only sit in my favourite chair as long as I like</p> <p><input type="checkbox"/> Pain prevents me sitting more than one hour</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 30 minutes</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes</p> <p><input type="checkbox"/> Pain prevents me from sitting at all</p>	<p>SECTION 10 - Travelling</p> <p><input type="checkbox"/> I can travel anywhere without pain</p> <p><input type="checkbox"/> I can travel anywhere but it gives me extra pain</p> <p><input type="checkbox"/> Pain is bad but I manage journeys over two hours</p> <p><input type="checkbox"/> Pain restricts me to journeys of less than one hour</p> <p><input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes</p> <p><input type="checkbox"/> Pain prevents me from travelling except to receive treatment</p>