ROSEVILLE ORTHOPEDIC
Surgery & Sports Medicine

151 N. Sunrise Ave, Suite 1005
Roseville, CA 95661
Tel: 916-782-1217
Fax: 916-782-7630
rosevilleorthopedics.com

Foot & Ankle Surgery Questionnaire

Patient name: _____

Date: _____

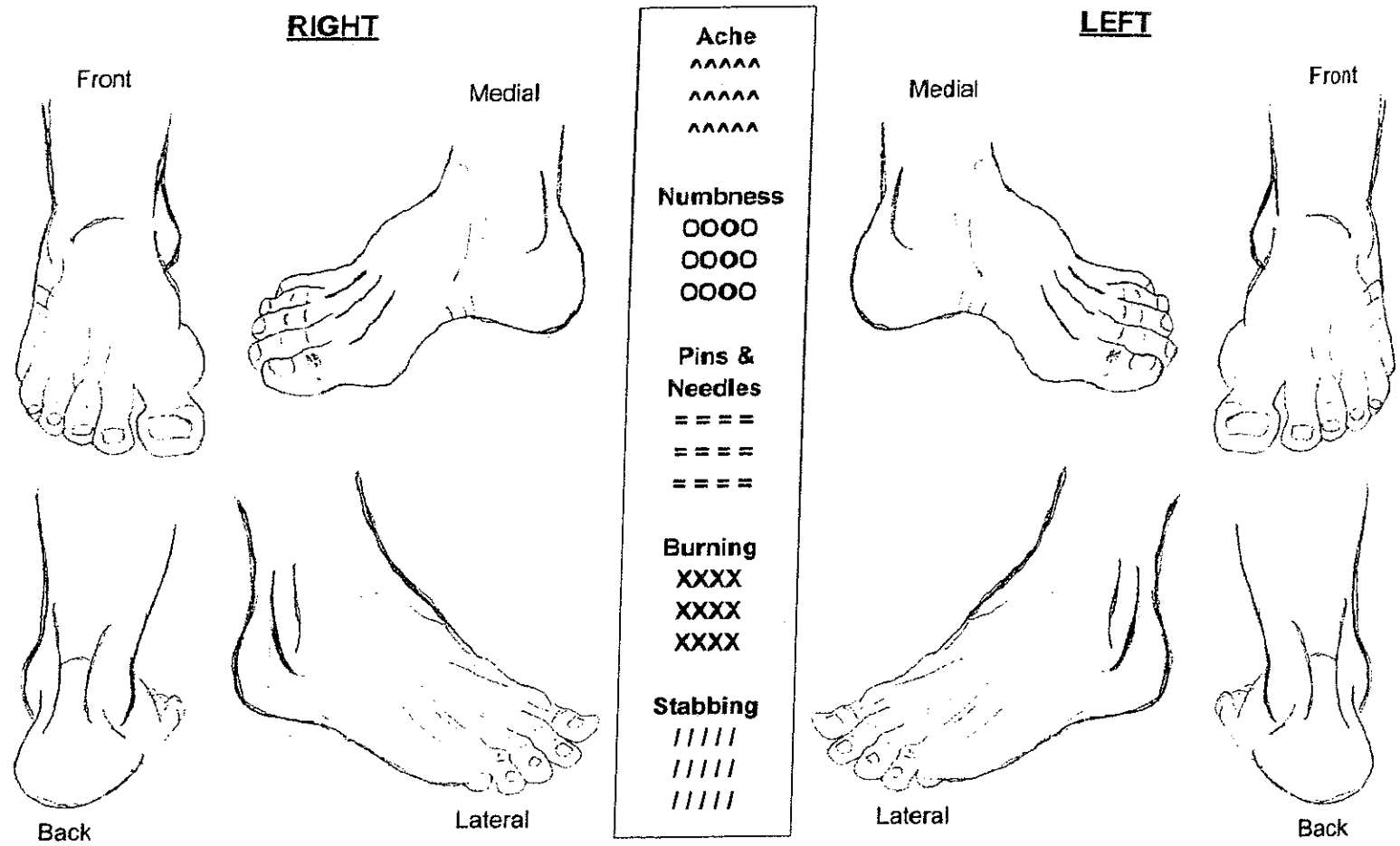
Age: _____ Date of Birth: _____

Primary Care Physician: _____

Referring Physician: _____

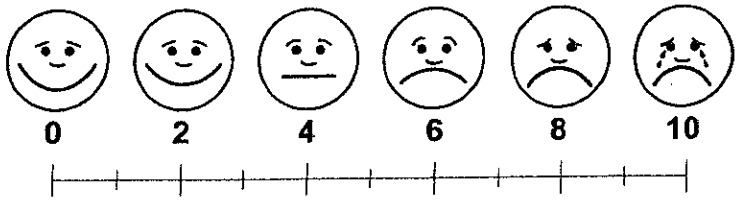
WHERE IS YOUR PAIN NOW?

Please mark the areas where you feel the following sensations.



Grade your overall Pain

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



Name: _____

CURRENT HISTORY

What is the main reason for your visit today?

_____

How long has this been a problem?

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

Have you been treated by any other healthcare provider for this condition? ❑ Yes ❑ No

If yes, please list: _____

Is there a lawsuit associated with this injury: ❑ Yes ❑ No If yes, attorney name: _____

Is this a workman's compensation claim: ❑ Yes ❑ No If yes, date of injury: _____

Current problem began: (Check all that apply)

❑ Suddenly ❑ Gradually ❑ Fall ❑ Other: _____

BRIEFLY describe how the problem started: _____

_____

What bothers you most about your foot and/or ankle? (check all that apply)

❑ Pain ❑ Swelling ❑ Numbness/Tingling ❑ Feels unstable ❑ Deformity

Current problem is: ❑ Getting worse ❑ Improving ❑ Stays the same ❑ Comes / Goes

Prior to the onset of your current problem:

- **Any recent increase in activities?** ❑ Yes ❑ No If so, please describe: _____
- **Any recent changes in shoe gear?** ❑ Yes ❑ No If so, please describe: _____

What type of shoes do you typically wear? _____

What distance can you walk before your symptoms begin?

❑ Unlimited ❑ 4 - 6 blocks ❑ 1 - 3 blocks ❑ less than 1 block ❑ Other _____

What have you tried for your symptoms thus far?: *(check all that apply)*

❑ Physical Therapy	❑ Acupuncture	❑ Altered shoe gear	❑ Altered Activity
❑ Surgery	❑ Brace	❑ Cortisone injection	_____
❑ Exercise	❑ Custom shoe inserts	❑ Soaks	❑ Medications
❑ OTC Shoe Inserts	❑ Padding		_____

Indicate which activities WORSEN your symptoms:

❑ Getting up from a seated position	❑ Standing	❑ Walking	❑ Running	❑ Shoe type_____
❑ Uneven ground	❑ Driving	❑ Household Chores	❑ Exercise_____	❑ Other _____

Is your pain worse:

❑ In the morning ❑ Mid-day ❑ In the evening ❑ Constant: _____

- **Are there any other general foot or ankle health information we should know about?** ❑ Yes ❑ No

If so, please describe: _____

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

❑ Regular X-rays ❑ CT Scan ❑ MRI ❑ Vascular non-invasive test ❑ EMG

Have you ever had foot or ankle surgery before: ❑ Yes ❑ No

Please list ALL prior surgeries with dates (Month/Year):

_____

_____

_____

_____

Name: _____

MEDICAL HISTORY

Do you have a history of:

Blood clots/excessive-bleeding	YES ❑	NO ❑	Arthritis	YES ❑	NO ❑
Diabetes	YES ❑	NO ❑	Hypertension	YES ❑	NO ❑
Adverse Reaction to Anesthesia	YES ❑	NO ❑	Cancer	YES ❑	NO ❑
Cardiac Disorders	YES ❑	NO ❑	Mental Health Disorders	YES ❑	NO ❑

Other diagnosis: _____

MEDICATION ALLERGIES

Are you allergic to any medications? ❑ Yes ❑ No

If yes, list the medications and your reaction.

Medication	Reaction
1.	
2.	
3.	
4.	

MEDICATION AND DOSAGE

If you brought a list, please attach.

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

SOCIAL HISTORY

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 on Disability: ❑ Yes ❑ No If yes, Date started: _____

Are you: ❑ Married/Partnered ❑ Single ❑ Divorced/Separated ❑ Widowed

Number of Children, if any: _____

Do you smoke or use Tobacco products: ❑ Yes ❑ No

If yes, for how long: _____

Packs smoked per day: ❑ <½ ❑ ½ ❑ 1 ❑ 2 ❑ 3 ❑ 4

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

Do you drink Alcohol: ❑ Yes ❑ No

If yes, how often: ❑ 1-2 ❑ 3-5 ❑ >5 per ❑ day ❑ week ❑ month

Do you use any recreational drugs: ❑ Yes ❑ No If yes, which drugs: _____

Name: _____

FAMILY HISTORY

List any blood relatives with a history of:

- ❑ Blood clots / excessive bleeding — Relationship _____
- ❑ Adverse reaction to anesthesia — Relationship _____
- ❑ Cardiac disorders — Relationship _____
- ❑ Cancer — Relationship _____
- ❑ Diabetes — Relationship _____
- ❑ Auto immune disorders — Relationship _____

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

			Please describe all yes answers
Skin	YES ❑	NO ❑	_____
Ears, Nose, Throat	YES ❑	NO ❑	_____
Cardiac/High blood pressure	YES ❑	NO ❑	_____
Lungs, (Asthma, Infection)	YES ❑	NO ❑	_____
Stomach/Digestion	YES ❑	NO ❑	_____
Bladder/Bowel problems	YES ❑	NO ❑	_____
Hematologic/Bleeding problems	YES ❑	NO ❑	_____
Diabetes	YES ❑	NO ❑	_____
Cancer	YES ❑	NO ❑	_____
Musculoskeletal	YES ❑	NO ❑	_____
Neurological	YES ❑	NO ❑	_____
Psychiatric problems	YES ❑	NO ❑	_____
Reproductive/Sexual Problems	YES ❑	NO ❑	_____
Fever/Chills	YES ❑	NO ❑	_____
Night Sweat	YES ❑	NO ❑	_____
Night Pain	YES ❑	NO ❑	_____
Unexpected Weight Loss	YES ❑	NO ❑	_____

Patient Signature: _____ **Date:** _____

*** Please hand-carry your prior films (Xray, MRI, CT, etc) with you to your appointment.**

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REGISTRATION FORM

(Please Print)

Today's Date:	Primary Care Provider:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former / Maiden Name):	Sex: ☐ F ☐ M	Age:	Birth Date: / /

Street address:	Social Security #:	Home Phone:
		Cell Phone:

P.O. Box:	City:	Email:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Race: ☐ Caucasian/White ☐ African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Pacific Islander ☐ Mexican ☐ Other Spanish ☐ Other:_____	Language: ☐ English ☐ Spanish ☐ Other:_____	Interpreter Needed: ☐ Yes ☐ No

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 give your insurance card and ID to the receptionist.)

Responsible Party if Minor Patient:	Birth Date: / /	Address (if different):	Home Phone:

Guarantor Employer Name:	Guarantor Employer Address:	Guarantor Employer Phone:

Name of primary insurance:	Subscriber Name:	ID / Policy #:	Group #:

Patient's Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of Secondary Insurance:	Subscriber's Name:	ID / Policy #:	Group #:

Patient's Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone:	Work Phone:
Alternate Contact Person:	Relationship to Patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Roseville Orthopedics & Sports Medicine** or insurance company to release any information required to process my claim(s).

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

Written Communication Address:

_____

____ OK to mail to address listed above

____ E-mail me at _____

Work Telephone Number:

_____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

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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Financial Policy

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 piece, we can relieve some stress and move toward a healthier life overall. Below is our financial policy.
The purpose of this form allows Roseville Orthopedic Surgery and Sports Medicine to treat you, bill any insurance you may have, share information with other health care offices and facilities, and to collect on your account.

REGARDING INSURANCE: Our office participates with many managed care insurance companies and with Medicare. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurance, deductibles, and non-covered services that have not been paid, are the responsibility of the patient and payment is expected at the time services are rendered. 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. We require payment when due to keep everyone's expenses to a minimum. If payment arrangements or general payment questions are needed, please contact our billing office at (209) 579-5628, Monday through Friday from 8:00am to 5:00pm.

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's not a guarantee the service will be fully paid. We may require you to pay a deposit, deductible or co-payment prior to surgery.

PRIVATE PAY: At the time of scheduling your office visit, you will be required to make a $150-$350 deposit depending on the nature of your appointment. The deposit will be applied towards your first visit. If you need to make payment arrangements, please contact our billing office. If you are able to pay in full at the time of service, you will receive a 10% discount.

NO SHOWS: Please be advised that if you do not show up for your appointment you will be charged $50 for No Show Appointment. This fee will not be covered by your insurance company and will be your sole responsibility. Please bear in mind this is only being done to better serve our patients by improving access to appointment times often taken by patients who have scheduled appointment and failed to utilize them.

We require a 24 hour notice in advance if you need to change your appointment to not be charged.

FORMS COMPLETION: It is our office policy to charge any request for correspondence such as letters of medical necessity and disability forms. The form fee is $25 for each form to be completed. If you require a CD of your x-ray the cost is $5. We require that you pick up your forms upon completion, you will receive a call from us.

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

Patient/Parent signature _____ Date _____

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

(800) 633-2322

www.mbc.ca.gov

DME

We will collect a deposit that will be applied to your co-insurance. We will bill your insurance for your DME product.

Based on your insurance coverage, your DME could be applied towards your deductible or not be a covered benefit.

We would bill you based on the determination of your benefit coverage plan.

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 _____