



# 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 <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 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:  <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, how often:  1-2  3-5  >5 per  day  week  month

Do you use any recreational drugs:  Yes  No If yes, which drugs: \_\_\_\_\_

### 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 <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: \_\_\_\_\_

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



**ROSEVILLE  
ORTHOPEDIC**  
Surgery & Sports Medicine

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

**REGISTRATION FORM**

(Please Print)

<b>Today's Date:</b>		<b>Primary Care Provider:</b>			
<b>PATIENT INFORMATION</b>					
<b>Patient's Last Name:</b>		<b>First:</b>	<b>Middle:</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
<b>Is this your legal name?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If not, what is your legal name?</b>	<b>(Former / Maiden Name):</b>		<b>Sex:</b> <input type="checkbox"/> F <input type="checkbox"/> M	<b>Age:</b> / /
<b>Street address:</b>			<b>Social Security #:</b>	<b>Home Phone:</b>	
				<b>Cell Phone:</b>	
<b>P.O. Box:</b>	<b>City:</b>	<b>Email:</b>		<b>State:</b>	<b>ZIP Code:</b>
<b>Occupation:</b>		<b>Employer:</b>		<b>Employer phone no.:</b> ( )	
<b>Race:</b> <input type="checkbox"/> Caucasian/White <input type="checkbox"/> African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Mexican <input type="checkbox"/> Other Spanish <input type="checkbox"/> Other:			<b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		<b>Interpreter Needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>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.</b>					
<b>WORKER'S COMP? <input type="checkbox"/> YES <input type="checkbox"/> NO    MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO    LITIGATION PENDING? <input type="checkbox"/> YES <input type="checkbox"/> NO</b>					

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card and ID to the receptionist.)					
<b>Responsible Party if Minor Patient:</b>	<b>Birth Date:</b> / /	<b>Address (if different):</b>		<b>Home Phone:</b>	
<b>Guarantor Employer Name:</b>	<b>Guarantor Employer Address:</b>			<b>Guarantor Employer Phone:</b>	
<b>Name of primary insurance:</b>	<b>Subscriber Name:</b>		<b>ID / Policy #:</b>	<b>Group #:</b>	
<b>Patient's Relationship to Subscriber:</b>	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
<b>Name of Secondary Insurance:</b>	<b>Subscriber's Name:</b>		<b>ID / Policy #:</b>	<b>Group #:</b>	
<b>Patient's Relationship to Subscriber:</b>	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

<b>IN CASE OF EMERGENCY</b>			
<b>Name of local friend or relative (not living at same address):</b>	<b>Relationship to Patient:</b>	<b>Home Phone:</b>	<b>Work Phone:</b>
<b>Alternate Contact Person:</b>	<b>Relationship to Patient:</b>	<b>Home Phone:</b>	<b>Work Phone:</b>

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:** \_\_\_\_\_

**Written Communication Address:** \_\_\_\_\_

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

\_\_\_\_ OK to mail to address listed above  
 \_\_\_\_ E-mail me at \_\_\_\_\_

**Work Telephone Number:** \_\_\_\_\_

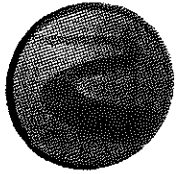
**Fax Communication:** \_\_\_\_\_

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

\_\_\_\_ 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](http://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 \_\_\_\_\_



**ROSEVILLE ORTHOPEDIC SURGERY and  
SPORTS MEDICINE**

**CREDIT CARD AUTHORIZATION AGREEMENT**

Roseville Orthopedic Surgery and Sports Medicine has implemented a new credit card policy. Like many other practices and medical offices, we have adopted a similar policy. We kindly request our patients' guardian/guarantor for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notify us of the balance due, if any. The information will be held securely until your insurance has paid its portion of the claim and notified us of any additional amount owed by the patient. At that time, we will bill the credit card up to \$500.00 maximum per month. If the balance owing is more than \$500.00, this will be billed the following month unless the patient contacts our billing office and would like the entire balance applied to the credit card in one month. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have questions about the card-on-file payment method, please tell us. Any CC charges will be sent by email as a notification.

By signing below, I authorize Roseville Orthopedic Surgery and Sports Medicine to keep my signature and my credit card information securely on file in my account. I authorize Roseville Orthopedics to charge my credit card for any outstanding balances when due, including prior open balances from 2023 and before.

Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/>	
Name on Card (Print): _____	MRN# _____
Cardholder Relationship to Patient: _____	
Last Four Digits of Credit Card Number: _____	Exp. Date: ____/____
Email: _____	
Please fill out the information below for any person(s) you authorize this credit card for:	
Patient Full Name (Print): _____	DOB: ____/____/____

Credit Card Holder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For any questions about the credit card or other billing questions, please call our billing office at (888) 461-7001.

PJ completed: \_\_\_\_\_ No prior PJ patient: \_\_\_\_\_ Date: \_\_\_\_\_

