



**ROSEVILLE
ORTHOPEDIC**
Surgery & Sports Medicine

151 N. Sunrise Ave, Suite 1005
Roseville, CA 95661
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rosevilleorthopedics.com

Dear New Patient,

We are pleased to welcome you to Roseville Orthopedic Surgery & Sports Medicine. We are very proud to have been serving the community with a tradition of excellence for over 50 years. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. As a result, we can offer you a proactive and expeditious recovery from your orthopedic problems.

Roseville Orthopedic Surgery & Sports Medicine is an independent group affiliated with Sutter Medical Foundation. Our shared electronic medical record allows us to receive patient results quickly and efficiently through our direct link with Sutter Medical Foundation services. This is an important resource for patients and referring providers, and we encourage you to take full advantage of My Health Online through the Sutter website. Likewise, www.rosevilleorthopedics.com has much of the information and details you may be seeking for your consultation with us. We encourage you to visit our website for general information, driving directions, and biographies of our surgeons.

In addition to your relevant imaging studies and medication lists, you will need to bring your current insurance card and a photo ID with you for your first appointment. We have also attached registration and medical history forms that need to be completed prior to arrival. All co-pays and past due balances are expected at time of service, unless prior arrangements have been made with our billing department.

To facilitate new patient registration, we ask that you arrive prior your scheduled check in time. We take your time and other commitments seriously, and strive to stay on schedule. As a courtesy to our other patients that are affected by delays, you may be asked to reschedule your appointment if you are more than 15 minutes late. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to reschedule or stay to be seen, and we will do our best to keep you informed of how long of a delay you may experience.

Providing the highest quality of professional care to our patients is very important to us. We encourage feedback and any suggestions on how we can make your time here with us comfortable. Welcome, and thank you for choosing our practice.

Sincerely,

The Doctors and Staff of Roseville Orthopedic Surgery and Sports Medicine



REGISTRATION FORM

(Please Print)

Today's Date:		Primary Care Provider:			
PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former / Maiden Name):		Sex: <input type="checkbox"/> F <input type="checkbox"/> 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: <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: _____			Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <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					

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:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of Secondary insurance:	Subscriber's Name:		ID / Policy #:	Group #:	
Patient's Relationship to Subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Subscriber Employment:	SS #:	DOB:	Work #:	Home #:	Address:

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/Guardian 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: _____

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



Medical Information

Primary Care Physician: _____ Patient Name: _____

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	_____	_____	_____	_____

Worker's Comp Carrier _____ Claim Number _____

Adjuster's Name _____ Phone Number _____

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

EARS, NOSE, THROAT

Hearing loss	Yes	No
ringing	Yes	No
Frequent nose bleed	Yes	No
Sore throat	Yes	No
Hoarseness	Yes	No

RESPIRATORY

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

GENITOURINARY

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

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

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

SYSTEM

EYES

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

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

SKIN

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

PSYCHIATRIC

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

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:



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 billing questions are needed please contact our billing office at (916)782-1217, Monday through Friday from 8:00am to 3:30pm, and follow the prompts for billing.

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 time of scheduling your office visit you will be required to make a \$150 deposit. If you cancel your scheduled office visit you will only be refunded \$75 of your deposit. The deposit of \$150 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 20% 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 \$20. 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 _____