Patient Registration

BARCODE

DO NOT WRITE

Last Name: _____

First Name: _____

Middle Initial _____ Preferred Name _____

Sex: _____ Date of Birth: _____

SSN: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Consent to call: YES or NO
(would you like to receive automated messages/text and alerts from our practice via your mobile number?)

Work Phone: _____

E-Mail: _____

Contact Preference: Hm Wk Cell Email Mail

Marital Status: _____

Language: _____

Race: _____ Ethnicity _____

How did you hear about us? _____

Referring Physician: _____

Primary Care Physician: _____

IS THIS ACCIDENT RELATED? Yes or No (Auto, Work, Other)

Emergency Contact Information:

Name: _____

Relation: _____

Phone: _____ Mobile: _____

Next of Kin: _____

Relation: _____

Phone: _____

Guarantor (name to whom statements are sent)

Guarantor Name: _____

Guarantor's relation to patient: _____

Guarantor's Address _____

Primary Insurance Information:

Type of Insurance: _____

Policy holder Name: _____

Relation to Patient: _____

Sex: _____ Date of Birth: _____

Social Security Number: _____

Policy ID Number: _____

Policy Group Number: _____

Employer Name: _____

Employer Phone: _____

Secondary Insurance Information:

Type of Insurance: _____

Policy holder Name: _____

Relation to Patient: _____

Sex: _____ Date of Birth: _____

Social Security Number: _____

Policy ID Number: _____

Policy Group Number: _____

Employer Name: _____

Employer Phone: _____

All fees whether they are covered by Insurance or not, are due/payable within 30 days unless other arrangements have been made. A service charge is applicable after this period, regardless of insurance status. It could be either 1 1/2 % per month (18%) annual percentage rate, or a minimum charge of $.50 cents. I hereby authorize my insurance benefits to be paid to the physician. I am financially responsible for all non-covered charges. I authorize the physician to release any information required by other physicians/agencies for the purpose of reimbursement to my account or pending treatment deemed necessary by my physician.

Signature: _____ **Date:** _____

ORTHOPEDIC ASSOCIATES OF NORTHERN CALIFORNIA P (530) 897-4500 F (530) 897-4544

131 Raley Blvd., Chico CA 6127 Clark Rd., Ste 200 Paradise, CA

Health Information

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Name:_____ DOB:_____ Date:_____

Primary MD:_____ Referring MD:_____ Scheduled to see today:_____

Briefly explain the reason for today's visit: _____

_____

Pharmacies that you have
Medications filled at

_____

Have you had any prior imaging for this problem (X-Rays, MRI, CT, EMG)? YES NO

1. Type of Exam: _____ Where: _____ Approx When: _____
2. Type of Exam: _____ Where: _____ Approx When: _____

IS THIS INJURY WORK RELATED: YES NO IS THIS INJURY AUTO RELATED: YES NO

IS THIS INJURY IN LITIGATION: YES NO ATTORNEY:_____

Treating Physicians

Please List all physicians you are currently treating with, and why

_____

_____

Medication Allergies & Reaction
YES OR NO

_____

_____

METAL ALLERGIY YES OR NO LATEX ALLERGY YES OR NO

Irritation with any type of Jewelry: Yes No Type of Jewelry: _____

Curent Medications (Prescription and Over the Counter)
Include Dosage, Directions and Prescribing Doctor

_____ _____

_____ _____

_____ _____

_____ _____

Patient Name _____ **Date**_____

Family History

Please indicate if Paternal/Maternal

(ie mother, father, sibling, grandmother, grandfather)

Condition	Relation
Arthritis	
Asthma	
Back Problems	
Bleeding Disorders	
Cancer	
Diabetes	
Heart Attack (MI)	
Heart Problem	

Condition	Relation
High Cholesterol	
Hypertension	
Orthopedic Problems	
Osteoarthritis	
Osteoporosis	
Pulmonary Embolism	
Rheumatoid Arthritis	
Other	

Other Conditions not listed above: _____

Social History

Smoking Status	Never Former Current
Tobacco-years of use	
Deaf or serious difficulty hearing	Yes No
Blind or serious difficulty seeing	Yes No
Difficulty concentrating/ remembering	Yes No
Difficulty walking or climbing stairs	Yes No
Difficulty dressing or bathing	Yes No
Difficulty doing errands alone	Yes No
Marital Status	
Number of Children	

Live alone or with others	
Single or multi-level home	
Education level	
Are you currently employed?	Yes No
Employer	
Occupation	
Occupational health risks	
Work related injury?	Yes No
Auto related injury?	Yes No
If injured, is litigation ongoing?	Yes No
Hand dominance	

General stress level	Low Medium High
Exercise level	None Occasional Moderate Heavy
Sporting activities	
Caffeine intake	None Occasional Moderate Heavy
Alcohol Intake	None Occasional Moderate Heavy
Alcoholic Drinks Per Day	
Has smoked since age	
Smoking-how much?	
Chewing Tobacco	
Illicit drugs	
Advanced directive	

Surgical History

Surgery	Y/N	Details
Appendectomy		
C-Section		
Cardiac Catheterization		
Gallbladder		
Gastrointestinal Surgery		
Genitourinary Surgery		
Heart Surgery		
HEENT Surgery		
Hernia		
Hysterectomy		
Neurosurgery		

Surgery	Y/N	Details
Oncology Surgery		
Orthopedic Surgery		
Pacemaker		
Plastic Surgery		
Renal Surgery		
Thoracic Surgery		
Thyroid Surgery		
Tonsillectomy		
Vascular Surgery		
Other		
Other		

Patient Name _____ **Date**_____

Past Medical History

Condition	Y/N	Notes
Anemia		
Anxiety Disorder		
Arthritis		
Asthma		
Bleeding Disorder		
Blood Clots		
Cancer		
Coronary Artery Disease		
Depression		
Diabetes		
GERD/Reflux		
Gout		
HIV or AIDS		

Condition	Y/N	Notes
Heart Attack (MI)		
Heart Disease		
Heart Problems		
Hepatitis		
Hernia		
Hypercholesterolemia		
Hypertension		
Kidney Disease		
Leg or Foot Ulcers		
Liver Disease		
Lung Disease		
Menopause		Age Started:
Migraines		

Condition	Y/N	Notes
Osteoporosis		
Pacemaker		
Peripheral Vascular Disease		
Pulmonary Embolism		
Rheumatoid Arthritis		
Seasonal Allergies		
Seizures/Epilepsy		
Stroke		
Thyroid Problems		
Tuberculosis		
Ulcers		
Urinary Tract Infections		

Review of Systems
(Please check all that Apply)

Constitutional: Fever □ Night Sweats □ Significant Weight Gain □ (lbs Gained_____) Significant Weight Loss □ Other □
Please explain any check marks above: _____
_____

Eyes: Dry Eyes □ Irritation □ Vision Change □ Other □
Please explain any check marks above: _____
_____

ENMT: **Ears:** Difficulty Hearing □ Pain □ Other □
Nose: Frequent Nosebleeds □ Nose/Sinus Problems □ Other □
Mouth/Throat: Sore throat □ Bleeding Gums □ Snoring □ Dry Mouth □ Mouth Ulcers □ Oral Abnormalities □ Teeth Problems □ Other □
Please explain any check marks above: _____
_____

Cardiovascular: Chest Pain □ Arm Pain on exertion □ Shortness of breath when walking □ Shortness of breath when lying down □ Palpitations □ Heart Murmur □ Chest pain on exertion □ Light-Headed upon Standing □ Other □
Please explain any check marks above: _____
_____

Respiratory: Cough □ Wheezing □ Sortness of breath □ Coughing up blood □ Sleep Apnea □ Other □
Please explain any check marks above:
_____

Gastrointestinal: Abdominal Pain □ Vomiting □ Change in appetite □ Frequent Diarrhea □ Vomiting blood □ Black or tarry stools □ Other □
Please explain any check marks above: _____
_____

Genitourinary: Incontinence □ Difficulty urinating □ Hematuria □ Increased urinary frequency □ Incomplete emptying □ Other □
Please explain any check marks above: _____
_____

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Patient Name _____ **Date**_____

Review of Systems-Continued

Musculoskeletal: Muscle Aches □ Muscle weakness □ Joint Pain □ Back pain □ Swelling in the Extremities □ Other □
Please explain any check marks above: _____
_____

Integumentary: Abnormal mole □ Jaundice □ Rashes □ Itching □ Dry Skin □ Growth/Lesions □ Other □
Please explain any check marks above: _____
_____

Neurologic: Loss of consciousness □ Weakness □ Numbness □ Seizures □ Dizziness □ Frequent or severe headaches □ Migraines □ Restless Leg □ Other □
Please explain any check marks above: _____
_____

Psychiatric: Depression □ Sleep Disturbances □ Feeling unsafe in Relationship □ Alcohol abuse □ Restless Sleep □ Other □
Please explain any check marks above: _____
_____

Endocrine: Fatigue □ Increased Thirst □ Hair Loss □ Increased Hair Growth □ Other □
Please explain any check marks above: _____
_____

Hematologic/Lymphatic: Swollen Glands □ Bruising □ Excessive Bleeding □ Other □
Please explain any check marks above: _____
_____

Allergy/Immunologic: Runny Nose □ Sinus Pressure □ Itching □ Hives □ Frequent Sneezing □ Reaction to Metals □ Other □
Please explain any check marks above: _____
_____

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HIPAA Disclosure Form

PRINT PATIENT NAME: _____

I. Please list the family members or the other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name_____ Relationship_____ DOB_____

Name_____ Relationship_____ DOB_____

Name_____ Relationship_____ DOB_____

Name_____ Relationship_____ DOB_____

II. Please list your primary care physician and any other physician's that you give us permission to release information to. This can include but is not limited to chart notes, op reports and diagnostic reports.

Physician_____ Specialty _____ Phone #:_____

Physician_____ Specialty_____ Phone#:_____

III. Medication History Authorization – Please indicate whether you (the patient or patient's representative) will grant us permission to download the patient's medication history automatically from our pharmacy benefit managers.
YES_____ NO _____

IV. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home. _____
_____

V. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":
YES_____ NO _____

VI. Please print the alternative daytime telephone number(s) where you would like to receive communications regarding your appointments, lab and x-ray results, and other health care information:
( )_____ ( ) _____

*** I am fully aware that a cellular phone is not a secure and private line***

VII. Can confidential messages be left on your answering machine or voicemail? YES_____ NO_____

VIII. I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet, or e-mail.

SIGNATURE: _____ DATE_____
(If Minor of 18 years Parent or Guardian Signature)

Patient Partnership & Financial Policy

(Version 1.3)

To Our Patients:

We are pleased you have chosen Orthopedic Associates of Northern California to provide your medical services. We are committed to providing you with the best possible medical care to meet your needs. Our practice firmly believes that to achieve our mission we must maintain a high level of understanding and good communication with our patients throughout the course of treatment. Just as we would communicate with you your treatment plan and importance to be compliant to ensure the best outcome, similarly we pride ourselves on communicating with you any anticipated out of pocket costs to create a better understanding and level of expectation. Our Patient Financial Partnership policy is designed to be completely transparent and together alleviate any surprises during your road to recovery and good health.

The following information is provided to clarify our policies concerning payment for professional services:

1. **Time of Collection:** Our front desk staff and/or kiosk system will be asking for copayments, out-of-pocket deductible or co-insurance, self-pay deposits, and outstanding balance payments when you check in for your appointment. Deductible and out-of-pocket costs will have been determined prior to your arrival by contacting your insurance company for these amounts and applying them to the estimated costs of your procedures & treatment. We accept many forms of payment, including cash, check, money orders, Visa, MasterCard, Discover, American Express, as well as Care Credit.
2. **Account Balances:** Financial estimates are not always exact; account balances reflect the final service(s) rendered and insurance benefits allowed under your plan. Unless other arrangements have been made, the following payment plans will be automatically set up. Account balances ranging from-
   - $10-$75 will be default to a Net 30-day payment plan
   - >$75-$200 will default to a Net 60-day payment plan
   - >$200-$350 will default to Net 90-day payment plan
   - Balances over $350 will default to a Net 120-day payment plan

   Extended plans will be considered on a case by case basis and must be secured with an ATM/Credit Card contract for the monthly payments. The automated payment date for the recurring payment will be a date in the month that best works for you.
3. **Care Credit Financing Option:** Our office proudly provides Care Credit as a way to finance your balance with interest rates as low as zero percent depending on the terms chosen.
4. **Uninsured or non-covered services:** Uninsured patients will be directed to the business office prior to scheduling services for financial counseling. A deposit towards treatment of $450.00 (minimum) is required at the time of your appointment.
5. **Patient Credits:** Credits are refunded after treatment by any provider in the practice has been completed and all claims have been finalized by your insurance.
6. **Missed Appointments:** All appointments that are missed or not cancelled within 24 hours are subject to a no-show fee. This applies to same day cancelations. The fee for office visits is $75 and $100 for MRI appointments. Reminder calls are provided 48 hours in advance to help you meet the 24 hour window. Notifying us timely helps us- to help you- remain compliant with treatment and get you rescheduled ASAP to help ensure a great outcome. It also helps us to help other patients that need that appointment time to also ensure their best outcome.

Please see page 2

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If you are consistently unable or unwilling to meet these new guidelines there is a possibility we may need to reschedule any future appointments or services until a time when you are able to do so. Additionally, any open account balance that reaches 90 days+ could be automatically transferred to our 3rd party collection partner. Please note a situation of this type would be considered on a case-by-case basis.

It is also *extremely important* that we be notified, *as soon as possible*, of any changes in your insurance status, or to your insurance carrier. This would include eligibility changes, becoming newly insured or uninsured, or acquiring additional, or new secondary coverage. Failure to do so will result in a direct balance billing to you under the direction of this policy since we will not be able to bill your insurance without this information.

Orthopedic Associates of Northern California understands that you may be facing stressful life events while you are acquiring our services. Our account specialist are here to help counsel our patients on our policies, and any insurance questions that arise. We hope to help you as much as possible through this process, and be an advocate for you as you navigate through the financial portion of your medical care.

If you have any questions about these policy changes we are happy to help you. Please contact your account specialist at **(530) 897-4500 option 5 or (530)-897-4545.**

Cordially,

Orthopedic Associates of Northern California

* *

In order to properly bill your insurance, please provide the following information:

Subscriber's full name _____
Subscriber's Social Security Number ____- ___-_____
Subscriber's Date of Birth ____/____/____
Patient's full name _____
Patient's Date of Birth _____-_____-_____
Patient's Social Security Number (if adult) _____-_____-_____

By signing below, you certify that you have received, read, and understand Orthopedic Associates Patient Financial Partnership Policy. Version 1.3

_____
Patient Signature **or**
Guardians Signature
(if patient under the age of 18)

_____
Relationship Name of Patient
(please print)

_____
DATE

ORTHOPEDIC ASSOCIATES of Northern California

BARCODE
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ANKLE/FOOT QUESTIONNAIRE Today's Date_____

PRINT NAME_____ **DATE OF BIRTH**_____

Which ankle/foot are we seeing you for today (please circle)? Right Left Both
Occupation:_____ Are you currently working: _____
Do you feel your injury is work related? Yes No
Is there an open work comp claim for this injury? Yes No
Is your claim in Litigation? Yes No

How was your ankle/foot injured (Include date, if any, and how long you have had a problem)?
_____
_____
_____

PAIN
Where in the ankle/foot does it hurt:_____
Frequency of pain: Constant Intermittent
Pain Scale (circle one): 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe
Aggravating activities (please circle):
Stairs (up/down) uneven ground pain at night running
pain with weight bearing prolonged standing/walking
Other:_____

Walking Aid used: None Cane Crutches Walker Wheelchair Motorized Scooter

Giving out or dislocations Yes No

Swelling Yes No

Loss of Motion Yes No

Prior ankle/foot Problems Yes No

Prior ankle/foot Surgery Yes No

Treatment Received for current condition
Medications _____
Injections _____
Physical Therapy (How many sessions) _____
Surgery _____
Other Physicians _____
Chiropractic _____
Ankle Braces _____
Other _____