# 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

BARCODE
DO NOT WRITE

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: _____
_____

BARCODE
DO NOT WRITE

**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: _____
_____

BARCODE
DO NOT WRITE

# 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

BARCODE

DO NOT WRITE

**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
DO NOT WRITE

# KNEE QUESTIONNAIRE

Todays Date:_____

**PRINT NAME**_____ **DATE OF BIRTH**_____

Which knee 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 knee injured (Include date, if any, and how long you have had a problem)?

_____

_____

_____

**PAIN**

Where in the knee 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 prolonged sitting running

climbing Squatting kneeling prolonged standing/walking

Other:_____

Walking Aid used: None Cane Crutches Walker Wheelchair Motorized Scooter

Giving out or dislocations Yes No

Locking, Catching, Clicking (circle all that apply) Yes No

Swelling Yes No

Loss of Motion Yes No

Prior Knee Problems Yes No

Prior Knee Surgery Yes No

Treatment Received for current condition

Medications _____

Injections _____

Physical Therapy (How many sessions) _____

Surgery _____

Other Physicians _____

Chiropractic _____

Knee Braces _____

Other _____