(All information MUST be completed in order to bill your insurance company)

Demographics

Patient's Last Name:_________________________ First Name:__________________________________ M.I.__________

Date of Birth:______________________________ Social Security Number:______________________________________

Street Address:____ _____________

City:______________________________________ State:____________________ Zip Code:________________________

Home Phone #:_____________________________ Work #:_________________ Cell #:___________________________

Email ____@____

Preferred Method of Contact: ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

Race: ❑ American Indian/Alaskan National ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander
❑ White ❑ Patient Declined

Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino ❑ Declined

Sex: ❑ Male ❑ Female

Occupation:____ Employer:__________________________________

Emergency Contact:____________________________________Relationship:____________Phone #:________________

Referring Physician:____ Phone #:______________________________

Insurance Information

Primary Insurance Company:____

Subscriber Name (Last, First):____ Date of Birth:______________________

Insurance Member ID #:____ Group #:_________________________

Secondary Insurance Company:____

Subscriber Name (Last, First):____ Date of Birth:______________________

Insurance Member ID #:____ Group #:_________________________

**I understand that I am liable for expenses incurred which are not covered under my medical plan and that all co-payments, deductibles and/or non-covered services are to be paid in full at the time of the service. I hereby authorize the release of any information to my insurance company necessary to process the claims. I hereby authorize my insurance company to make payments directly to the physician. ________ (Initials)

Signature:____ Date:___________________________

Print Name:____

Financial Policy

We would like to thank you for choosing Advanced Orthoapedics as your medical provider. To keep you informed of our current office and financial policies, we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Cancelled appointments: We request a 24 hour notice in the event that you cannot keep your scheduled appointment. This will enable us to use your slot for other patients.

Insurance: Please bring your insurance card with you at the time of your appointment. We will file your insurance claim for you. You will be responsible for any deductible, co-insurance and services not covered by you plan. Please remember that you insurance is a contract between you and you insurance company. While we assist you by filing you claim, you be responsible for any balance which is indicated on their explanation of benefits (EOB) form.

Payment: All payment is due at the time the service is rendered, unless payment arrangement has been approved in advance. We accept checks, Visa, MasterCard and cash. Returned checks are subject to additional service charges.

Co-Payments: All co-payments are expected at the time of service, unless other financial arrangements have been made prior to your visit.

HMO's: Your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving any services.

We do offer health financing through Care Credit, should you ever need financial assistance. Please see the office manager for additional information.

I have read and understand this financial arrangement and realize that all fees regardless of the insurance coverage are ultimately my responsibility.

Patient Signature or Responsible Party:_______________________________________ Date:_______________

Print Name:____

6140 Camino Verde Dr. Suite L|San Jose, CA 95119
3800 J St Suite 220 | Sacramento, CA 95128
Phone: (408) 224-1267 Fax: (408) 926-6858

Consent to Release Records

Patient Name: ______________________ Date of Birth: ______________

Reason for transfer/copy ______________________________________

____

I hereby authorize as needed and request Advanced Orthopaedics to (family member, PCP, attorney, etc.)

○ Release Information to Or ○ Obtain Information From

____

Information To Be Disclosed

- ○ Medical Records from (Date) ______________ To (Date) ______________
- ○ Entire medical history, including patient history, office notes, test results, radiology studies, films, referrals, etc.
- ○ Other ______________________________________

____

I understand that:

- ○ Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- ○ I can cancel this authorization at any time by writing to Advanced Orthopaedics. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- ○ Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

______________________________________ ______________________

Patient/Parent/Guardian/Legal Representative Signature Date

____

Printed Name & relationship to patient, if applicable

ADVANCED ORTHOPAEDICS

Policy on Narcotic Pain Medication

Unfortunately, it is very likely that all patients that seek help from an orthopedic surgeon have some degree of pain. One of the goals of seeking help is pain relief besides restoration of function. Since the majority of pain medications are narcotics or substances closely related to narcotics every medical office needs a policy as these substances are controlled by law enforcement. The reason for this is the potential for addiction and abuse and all its associated problems.

- **NO** narcotics or Anxiety medications will be called in under ANY circumstances.
- Narcotics **CANNOT** be called into a pharmacy as they are controlled substances.
- Since narcotic medications need to be documented and controlled, **a prescription for the medication(s) requires an office visit** minimum every 3 months or as directed by the provider.
- **NO** automatic refills will be given for narcotics.
- **NO** calls regarding narcotics will be answered after hours or on weekends.
- Please take ALL medications as directed- **NO EARLY REFILLS OF ANY MEDICATIONS WILL BE AUTHORIZED.**
- **NO** prescriptions will be replaced for any of the following reasons:
    - “My dog/cat/bird ate my medication”
    - “My sister/mother/brother/child/roommate/prison buddy stole them”
    - “I left them in my pants and accidently washed them in the washing machine”
    - “I threw/dropped them in the toilet”
    - “They were in my car which was stolen/impounded/burned down”
    - “I moved and can’t find them”
    - “I am leaving out of town for an extended period of time and need additional medication”

Preferred Pharmacy

Pharmacy name: ______________________________

Phone Number & Address: ______________________________

1. If it is discovered that you are receiving narcotics from another physician, that physician will be notified, we will immediately discontinue your medication and notify your pharmacy.
2. If there is acute pain for a new condition for which the patient seeks treatment elsewhere, our practice must be called to let us know of the other physicians prescribing, and at that time we may adjust your pain medication.
3. By signing this policy you agree to solely receive narcotic prescriptions from my office.

Please acknowledge that you have read and understand the policy by signing this agreement.

**No medications will be prescribed if this policy is not signed.

Patient Signature or Responsibly Party:____ Date:____________________

Print Name:____

ADVANCED ORTHOPAEDICS

☐ 6140 Camino Verde Drive Suite L San Jose, CA 95119
☐ 3800 J st suite 220 Sacramento, CA 95128

Blood Pressure: /

Health Questionnaire

First Name: ______________________________ Last Name: ______________________________

Date of Birth: _____________ Age: __________ Height: ___________ Weight: _________

Marital Status: **Single** **Married** **Divorced** **Other** (**Circle one**) Number of Dependents: __________

Are you **right** or **left** handed? (**circle one**) Male_____ Female_____

Who is your Primary Care Physician? ____________________________Phone:_________________

Who referred you to Advanced Orthopaedics?
Friend ☐ Insurance Website ☐ Yelp☐ Google☐
Doctor _________________ Hospital ___________________

Which Body Part would you like to discuss (**circle**) Circle one or both (**Left** or **Right**)

Neck	**Pelvis**	**Upper Arm**	**Wrist**	**Thumb**	**Shin**
Low Back	**Hip**	**Elbow**	**Hand**	**Thigh**	**Ankle**
Mid Back	**Shoulder**	**Forearm**	**Finger**	**Knee**	**Foot**

When did the current problem start: ____

How did it start? (**Accident, Sudden onset, Just started hurting, Slow onset etc…)**_________________

____

What symptoms do you currently have? (**Please, circle all that apply)**

Pain **Instability** **Locking** **Clicking or Popping** **Numbness** **Swelling** **Bruising**

Describe the pain (**Faint, Sharp, Dull, Tingling, Burning**) ____________________________________

Describe the severity (**Minimal, Mild, Moderate, Severe**) ____________________________________

Describe the timing (**Occasional, Intermittent, Constant**) ____________________________________

Is this problem work related? _________________

Have you had x-rays? __________Which Body Part?__ ___________ Where was it taken? _____________

Have you had an MRI? __________Which Body Part? ___________ Where was it taken? _____________

Please, indicate with an X if you have had any of the following treatment for your current medical condition?

Shots **Physical Therapy** **Chiropractor** **Surgery** **Medications**

Are you currently taking any medication for other medical issues? If so, please list:__________________________

____

Have you had prior surgeries? __________________ If so, please list date, procedure and type of anesthetic:

Date: Procedure: Anesthetic:

__________ ____ _____________________

__________ ____ _____________________

__________ ____ _____________________

Do you have any other medical conditions?

High Blood Pressure		High Cholesterol	
Arthritis		Rheumatoid Arthritis	
Psoriasis		Hepatitis	
Lupus		Multiple Sclerosis	
Diabetes		Vascular Disease	
Stomach Ulcer/ GERD		Heart Disease	
Emphysema, Asthma		Depression	
Blood clots		Bladder Problems	
Infections		Cancer	

Others: ____

Do you have allergies to any medication? ____

Do you have allergies to latex? ____

Are there any medical conditions in your immediate family (**please describe below**)

Age: Mother:_______ Father: _______

High Cholesterol
High Blood Pressure
Heart Disease

Stroke
Blood Clots
Diabetes

Cancer
Arthritis
Autoimmune Disease
Hereditary Disease

Others: ____

Are you taking any recreational drugs? Yes _______ No _______

If so, please list: ____

Do you smoke? _________________ How Much? Daily ___ Weekly _____ Monthly ______

Do you drink Alcohol? ___________ How Much? Daily ___ Weekly _____ Monthly ______

Are you retired? _________________ Are you disabled? Temporary_____ Permanent _____ No_______

Do you work? _______________ ___ Part-Time___________ Full-Time:_____________

What is your profession? ____

Are you currently suffering from any of the following symptoms?

Change in weight		Fever		Night sweats	
Difficulty Sleeping		Lumps		Rash	
Change in moles		Problems swallowing		Wheezing	
Change in vision		Coughing		Fainting	
Problems hearing		Palpitations		Red Urine	
Nose bleeds		Urgency to Urinate		Cramps	
Shortness of breath		Vomiting		Black stools	
Chest pain		Heartburn		Varicose Veins	
Urine burning		Blood clots		Muscle cramps	
Nausea		Muscle Pain		Weakness	
Diarrhea		Back Pain		Memory Loss	
Swollen ankles		Change in memory		Change in speech	
Joint Pain		Depression			
Stiffness		Anxiety			

Signature: ____ Date: ___________________