PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient Name	Last	First	Date of Birth	Age
Street Address			❑ Male ❑ Female	
City	State	Zip Code	Social Security Number	
Home Phone	Work Phone	Cell Phone	E-Mail	
Employer Name	**Occupation**	**Employment Status** ❑ Full ❑ Part ❑ Ret	**Work Injury?** ❑ Yes ❑ No	**Auto/MVA Related?** ❑ Yes ❑ No

Primary Care Physician: **Phone:**

Who Referred You To Our Office?

❑Family Physician ❑Other Physician_____ ❑Friend ❑Insurance Company ❑Lawyer ❑Other_____

Have You Been Seen By Any Physician In This Practice Before? ❑No ❑ Yes When? Which Doctor?

Emergency Contact Name: **Relationship:** **Home or Cell Phone Number:**

INSURANCE INFORMATION (Please Present Insurance Cards to Receptionist)

Primary Insurance Company Name and ID#

Secondary Insurance Company Name and ID#

❑Check here if you believe Worker's Compensation is responsible for payment

HISTORY OF PROBLEM (specify LEFT or RIGHT)

Please specify the body part and area of pain.	
First Date of Injury or Symptom	
How Did Injury Occur & Where?	
Please indicate all symptoms that apply to this body part.	❑Instability ❑Locking/catching ❑Muscle spasm ❑Dislocation ❑Gives out ❑Grinding ❑Numbness ❑Locks up ❑Stiffness ❑Decreased range of motion ❑Popping ❑Weakness ❑Swelling ❑Difficulty climbing stairs ❑Pain with throwing/reaching
Describe the pain.	❑Sharp ❑Dull ❑Cramping ❑Radiating ❑Aching ❑Burning ❑Electrical/Nerve-Type
Radiology Studies (if any)	❑ X-ray ❑MRI ❑CT Scan ❑Bone Scan
Relevant Medications	
PREFERRED PHARMACY	

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize California Sports and Orthopaedic Institute to release information regarding my treatment or examination rendered to me for medical or surgical care to my insurance company (s) or its representatives. I also authorize payment to be made directly to California Sports and Orthopaedic Institute in the amount due for all medical and/or surgical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company (s). Furthermore, I authorize California Sports and Orthopaedic Institute to obtain my medical records from any necessary hospital, clinic, or doctor's office.

SIGNATURE X DATE

CALSPORTS & ORTHOPAEDIC INSTITUTE

PATIENT HEALTH QUESTIONNAIRE

PAST MEDICAL HISTORY: Please list all past medical history including any medications and current status

High Blood Pressure	❑ Yes	❑ No	Medication and Status: _____
Diabetes	❑ Yes	❑ No	Medication and Status: _____
Osteoarthritis	❑ Yes	❑ No	Medication and Status: _____
Heart Disease	❑ Yes	❑ No	Medication and Status: _____
Osteoporosis	❑ Yes	❑ No	Medication and Status: _____
Depression	❑ Yes	❑ No	Medication and Status: _____
High Cholesterol	❑ Yes	❑ No	Medication and Status: _____
Thyroid	❑ Yes	❑ No	Medication and Status: _____
Heart condition	❑ Yes	❑ No	Medication and Status: _____
Stomach Ulcers	❑ Yes	❑ No	Medication and Status: _____
Arthritis, Gout, Rheumatism	❑ Yes	❑ No	Medication and Status: _____
Painful or swollen joints	❑ Yes	❑ No	Medication and Status: _____
Muscle weakness/atrophy	❑ Yes	❑ No	Medication and Status: _____
Skin Conditions	❑ Yes	❑ No	Medication and Status: _____
Blood/Clotting Disorder	❑ Yes	❑ No	Medication and Status: _____
Stroke	❑ Yes	❑ No	Medication and Status: _____
Asthma/COPD	❑ Yes	❑ No	Medication and Status: _____

OTHER:

ALLERGIES AND SENSITIVITIES: Please indicate any allergies you are aware of in the space below.

Antibiotics (please specify)	❑**Yes**	❑**No**	❑**Unsure**	Name:	Reaction:
Narcotics (please specify)	❑**Yes**	❑**No**	❑**Unsure**	Name:	Reaction:
Pain Medication (please specify)	❑**Yes**	❑**No**	❑**Unsure**	Name:	Reaction:
Sulfur Drugs	❑**Yes**	❑**No**	❑**Unsure**		Reaction:
Tetanus/Antitoxin/other serums	❑**Yes**	❑**No**	❑**Unsure**		Reaction:
Adhesive or surgical tape	❑**Yes**	❑**No**	❑**Unsure**		Reaction:
Any foods (please specify)	❑**Yes**	❑**No**	❑**Unsure**	Name:	Reaction:
Other (please list):					

PAST SURGICAL HISTORY: Please list all past surgical procedures. Attach additional sheets if necessary.

Procedure:	**Date:**	**Surgeon:**

FAMILY HISTORY: Do you have a family history of the any of the following conditions, list the family members affected.

Cancer	❑**Yes**	❑**No**	Family Member:
Diabetes	❑**Yes**	❑**No**	Family Member:
Osteoarthritis	❑**Yes**	❑**No**	Family Member:
Heart Disease	❑**Yes**	❑**No**	Family Member:
Other:			Family Member:

SOCIAL HISTORY:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other _____

Weight: _____ **Height:** _____ **Primary Language:** _____ ❑ Decline
Race: _____ ❑ Decline **Ethnicity:** _____ ❑ Decline

Tobacco Use? ❑ Never ❑ Former ❑ Every Day ❑ current **Indicate here if use is a smokeless or e-cigarette** ❑
Alcohol: Beer, Wine, Liquor ❑ Never ❑ Rarely ❑ Weekly ❑ Daily Type/Amount _____
Illicit Drug Use: ❑ Yes ❑ No Type: _____

Hobbies, Sports, & Other Activities:

2999 Regent Street Suite 225 , Berkeley CA, 94705 / (510) 704-7760 FAX (510) 704-7765
350 30th Street Suite 530, Oakland California, 94609 / (510) 422-5150 FAX (510) 422 5149
25 Orinda Way Suite 100-A, Orinda CA 94563 / (925) 258-9571 FAX (925) 258-9572

Acknowledgement of Receipt of Notice

I understand Cal Sports is required by law to maintain the privacy of and provide individuals with access to the Notice of Our Legal Duties and Privacy Practices with respect to protected health information

I hereby acknowledge that I can receive a full copy of this medical practice's Notice of Privacy Practices.

Name of Patient: _____DOB:_____

Signed: _____ Date: _____

If not signed by the patient, please indicate your relationship to the patient, print your name and provide a telephone number below

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator/POA of an incompetent patient

Print Name: _____ Telephone: _____

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

by e-mail at: _____.

_____

***For Office Use Only*:** Signed form received by: _____

- ❑ Acknowledgment refused:

Reasons for refusal:

_____

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FINANCIAL POLICY California Sports and Orthopaedic Institute Tax ID: 56-2491950

Thank you for choosing California Sports and Orthopaedic Institute for your medical care. We are committed to providing you and your family with quality care. In turn, you are committing to financial responsibility for the medical services provided by our office. It is important for our patient/physician relationship that you read and understand our financial policy.

Insurance - We participate with many Insurance plans and require that you present your current insurance card/cards at the time of visit. If you are insured by a plan that we participate with but do not provide insurance information or we are not able to verify your coverage, payment in full is required at the time of your appointment**.**
Medicare - Medicare will be billed by Cal Sport. Covered services are determined by Medicare. You are responsible for paying your annual deductible and co-insurance amounts if they are not paid by your Secondary Insurance. **Please note most Cal Sports providers are NOT contracted with Medi-Cal** therefore the patient is responsible for the amount that can not be billed to that Insurance.
If your insurance delays payment -If your insurance carrier does not make payment within 90 calendar days, the balance in full will be due from you.
Copays - will be collected when you check in for your appointment. A $20.00 fee will be applied if payment of the Copay is declined by the patient at check in.
We do not bill third-party insurance.
Self Pay - If a patient does not have insurance they are considered self pay. Payment for the appointment and any other services provided will be collected from the patient at the time of service.
Referrals - If your Insurance Plan requires a referral form from your Primary Care Physician it your responsibility to obtain the form prior to your appointment. If we have not received your referral and you do not have a copy, your appointment may be rescheduled.
Worker's Compensation - If you are seeing one of our physicians due to a work-related injury we must have written authorization from your adjuster before you arrive for your appointment.
Parental Consent - Our office cannot be involved in negotiating payment for divorce orders regarding medical bills. The parent that accompanies a patient under the age of 18 will be responsible for presenting **current insurance information and will be required to issue any necessary Copays or balance due amounts.**
Payment - We accept cash, MasterCard, Visa, debit cards and personal checks. Returned checks incur a $30.00 fee.
Delinquent accounts - balances present for 3 statement runs are considered delinquent. Those accounts are marked as "Bad Debt" and may be assigned to an outside collection agency. It is imperative that **you update your address and contact information with us.**

I have read and understand the above noted policies

Patient Name_____

Patient/Guardian Signature_____Date_____