

## Bay Area Orthopedic Surgery and Sports Medicine

100 Hospital Drive  
Suite 303  
Vallejo, CA 94589  
Ph: 707-645-7210 Fax: 707-645-7249

Dear Patient;

Thank you for choosing our practice and we look forward to meeting you at your new patient consultation.

When preparing for your consultation with our office please review the following.

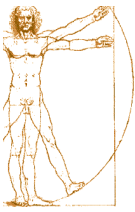
- Please complete the online (www.baosurgery.com "patient forms") paperwork in BLACK ink and bring it with you to your appointment or we may pre-register your packet if received prior to your appointment. This may be completed by mailing, emailing or faxing your packet. If you do not pre-register please arrive at least 45 minutes prior to allow us adequate time to process your paperwork.
- If an X-ray order is included in your packet please have completed on the day prior to your appointment. Please call our office if you have never had any radiological testing or if they are older than 6 months old. We may need to order X-Rays prior to your consultation.
- Please bring or wear a pair of shorts if you are being seen for your knee or hip. Please bring or wear a sleeveless shirt if you are being seen for your shoulder.
- If you are in need of directions please visit our website, [www.baosurgery.com](http://www.baosurgery.com).
- Please enter through the "Medical Offices" entrance of our building.
- Remember if you are unable to keep your appointment, please call us one business day ahead of time so another patient may utilize your appointment. Our practice charges \$25.00 for appointments that are not cancelled in the 24 hour requirement.

If you have any questions or concerns please feel free to call our office at the number above and we will be happy to assist you.

As a method of providing the best patient care please complete our online patient survey after your visit with our practice.

Sincerely,

Medical Staff  
Bay Area Orthopedic Surgery and Sports Medicine



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## CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT

This is an agreement between the patient and the doctor to help facilitate the legal distribution of controlled substances for the relief of chronic pain. I understand the treatment goal while using these controlled substances is to improve my ability to function and to alleviate the anguish of pain. I realize that my pain may not totally be alleviated by the use of controlled substance medication (narcotics)

### PATIENT RESPONSIBILITIES

\_\_\_\_\_  
INITIAL I am responsible for my medication. If the prescription or medication is lost, stolen, or misplaced, **I UNDERSTAND THAT THE MEDICATION WILL NOT BE REPLACED.**

\_\_\_\_\_  
INITIAL Pain medication can cause drowsiness, especially when taken with other sedating drugs. I will not drink alcohol while taking the prescribed pain medication. I will use caution when taking other sedating drugs, including over the counter non-prescription medication (such as anti-histamines).

\_\_\_\_\_  
INITIAL I will take all medication as prescribed. If my pain is relieved or lessened, I will gradually taper down the amount of medication I am taking. If I use all of the medication sooner than the duration prescribed, **I UNDERSTAND THAT THE MEDICATION WILL NOT BE REFILLED SOONER.**

\_\_\_\_\_  
INITIAL I understand that refill request must be received by noon the day prior to designated refill days. **There will be no exceptions.**

\_\_\_\_\_  
INITIAL I will contact my pharmacy 48 hours prior to the date my medication runs out. My pharmacy will FAX the request to the office for approval. I understand that my medication will not be approved if I request a refill before the 48 hours refill date.

\_\_\_\_\_  
INITIAL Only **one health care provider** (MD, PA, or NP) will prescribe all narcotic type medication at any given time. I understand that if I receive narcotic medication from multiple providers that is grounds for **IMMEDIATE TERMINATION FROM CARE.**

\_\_\_\_\_  
INITIAL I will receive all controlled substance medication (narcotics) from **one pharmacy. I AGREE TO NOT EXCEED THE AMOUNT OF MEDICATION PRESCRIBED.**

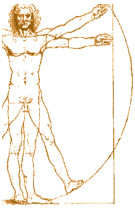
I have read and fully understand the above policy on medication refills.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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(Please Completely Fill in Form)

Name: \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

**Past Medical History:** (Please place a mark on "Yes" or "No" to indicate if you have had any of the following):

- |                     |  |                      |  |                         |  |
|---------------------|--|----------------------|--|-------------------------|--|
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Angina                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HTN                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoarthritis       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | COPD                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joints or Implants      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coronary Artery Dis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke (CVA)            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disorder      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypothyroid          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hyperthyroid            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Weight loss         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Clots          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypercholesterolemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes: Type I    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes: Type 2     | <input type="checkbox"/> Yes <input type="checkbox"/> No |                         |  |

**Surgical History:**

\_\_\_\_\_  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Current Medications:**

**Pharmacy:** \_\_\_\_\_

Name	Strength	Dosage	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies:** \_\_\_\_\_ **Reaction:** \_\_\_\_\_ **No Known Drug Allergies**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:** (summarize any above)

Cigarette/Tobacco:  Yes  No; # of Years: \_\_\_\_\_ Alcohol:  Yes  No Qty: \_\_\_\_\_

Employed:  Yes  No Occupation: \_\_\_\_\_

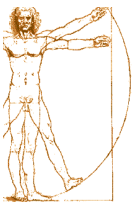
Marital Status (please circle) S M W D Pregnant:  Yes  No  N/A

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pain Level (1-10) \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I hereby authorize Bay Area Orthopedics and Pain to administer and perform such procedures that may be deemed necessary in the diagnosis and treatment.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Personal Information

Patient Name: \_\_\_\_\_  
Last First MI.

Guarantor Name: \_\_\_\_\_  
Last First MI.

Patient Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Reminder Call Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Is it OK to leave messages on your answering machine concerning the nature of our phone call Yes No

Is there another person you authorize our office to discuss your care/treatment with? \_\_\_\_\_

Sex (circle) M F Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Marital Status: S M D W

Social Security \_\_\_\_\_ - \_\_\_\_\_ Drivers License: \_\_\_\_\_

## Employment Information **(Fill out for parent or guardian if patient is a minor)**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Primary Care Information

Provider Referred By \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## **Insurance Information (If a work related injury please skip and continue on back of form)**

### **PLEASE COMPLETE THIS FORM IN ITS ENTIRETY**

#### **Primary**

Insurance Name \_\_\_\_\_ Policy ID # \_\_\_\_\_

Group# \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Patient's relationship to the subscriber: (circle) SELF SPOUSE CHILD OTHER \_\_\_\_\_

#### **Secondary**

Insurance Name: \_\_\_\_\_ Policy ID # \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Patients relationship to the subscriber: (circle) SELF SPOUSE CHILD OTHER \_\_\_\_\_

#### **Third**

Insurance Name: \_\_\_\_\_ Policy ID # \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Patients relationship to the subscriber: (circle) SELF SPOUSE CHILD OTHER \_\_\_\_\_

**Consent to the use and disclosure of Health Information**

I hereby authorize the providers of Bay Area Orthopedics to retain all of my medical records / information in an electronic format. These records will be maintained in a secured, confidential manner and shall be in compliance with HIPAA Regulations for patient confidentiality. These records shall not be released without consent of the patient or legal guardian. This authorization remains in effect until revoked in writing. I understand that I have been provided a copy of the *Notice of Privacy Practices* and that a full version is available and also posted in this office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Authorization and Assignment**

I hereby authorize Bay Area Orthopedics to furnish information to the insurance carrier (s) regarding my treatments. This authorization remains in effect until revoked in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Obligations (see attached Practice Financial Policy BAO 1004)**

I hereby assign, Bay Area Orthopedics all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by my insurance at the time of service to include co-pays, deductibles and non-covered services. I also understand that if I do not fulfill my payment obligations to Bay Area Orthopedics my account will be subject to a full collections process. Any expenses related to the cost of collections and/or legal proceedings will be my responsibility. I acknowledge I have read a copy of the Practice's Financial Policy BAO 300 and that a copy will be made available for me to keep upon my request or I may retrieve it from [www.baosurgery.com](http://www.baosurgery.com).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medicare Patients Only**

All Medicare patients must sign a lifetime beneficiary claim authorization. I request that payment of authorized Medicare benefits be made on my behalf to Bay Area Orthopedics for any services furnished by my doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of the medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the electronically submitted claims, physicians or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

**Additional Information - To be completed only if a Work Related Injury or Third Party Claim**

\_\_\_ Workers Compensation Claim      \_\_\_ Third Party Liability      Date of Injury \_\_\_/\_\_\_/\_\_\_

Insurance Company: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

If Worker's Compensation, Name and Address of Employer at time of injury:

\_\_\_\_\_  
\_\_\_\_\_