NAPA VALLEY ORTHOPAEDIC

MEDICAL GROUP, INC.

3273 CLAREMONT WAY, SUITE 100, NAPA, CA 94558 | main: 707.254.7117 | fax: 707.265.6435

Patient Information

Patient Name/Nombre____

Birth date/Fecha de Nacimeinto_____________Age/Edad_____Sex/Sexo____

How do you prefer to be addressed by our physicians and staff?____________________
Como prefiere que le llamen los doctores y las personas de la oficina?

Address/Domicilio____

City, State,Zip____
Ciudad,Estado,ZonaPostal

Home Phone____________________ Cell Ph______________________________
Numero de Telephono Numbero de cellular

Social Security #__________Drivers License #___________Marital Status___________
Numero de Seguro Social Licencia de Manejar Estado Civil

Employer________________________________WorkPh____________________
Nombre del Empleador

Work Address____
Domicilio del Empleador

City, State,Zip____
Ciudad, Estado, Zona Postal

Occupation____________________Nature of Business_________________________
Ocupacion Tipo de Negocio

Referred by____
Referido por__

Is this your Primary Care Dr___If no, Name of Primary Care Dr____________________
Es este to Doctor Primario Si no, Nombre del Doctor Primario.

Emergency Contact
Name/Phone____
Contacto de Emergencia Nombre/Telefono

May we leave a message at your home? With a person____ On answering machine?___
Podemos dejar mensaje en su casa? Con una persona En la maquina de mensajes

May we leave a message at your work? With a person? ______On voicemail?______
Podemoso dejar mensaje en su trabajo? Con una persona? En el correo de voz?

Is this visit related to a Work Injury____________If yes, Date of Injury______________
Es esta visita relacionada con lesion de trabajo Si si, fecha de lesion

Is this visit related to an accident? ___________Is this visit related to an injury?______
Es esta visita relacionada con accidente? Es esta visita relacionada con lesion?

If yes, Date of Accident or
Injury____
Si si, Fecha de Accidente o Lesion

Briefly describe circumstances____
Brevemente describa la circunstancia

____

Responsible Party if Other that Patient:
Persona Responsable si otra del paciente:

Name____Rel to Patient________________________
Nombre Relacion al Paciente

Address____
Domicilio

City, State, Zip____
Ciudad, Estado, Zona Postal

Phone___________________________________work phone_________________________________
Numero de Telefono Telefono del Empleador

Employer________________________________Occupation__________________________________
Nombre del Empleador Ocupacion

Primary Insurance Company

Insurance Company Name and
Address:____
____
Nombre Y Domicilio de Aseguranza

Group Number____________________________ID#__________________________________
Numero de Grupo No de Identificacion de Aseguranza

Subscriber
Name___________________________________Birthdate_______________________________
Nombre del Asegurado Fecha de Nacimiento

Subscriber Address ____
If different from patient
Direccion del asegurado si diferente a la del paciente

Subscriber Phone:___________________________Relationship to Insured___________________
Telefono del Asegurado Relacion con el asegurado

Copay Amount:_______________
Co Pago

Secondary Insurance:

Insurance company Name and
Address:____
____
Nombre Y Domicilio de Aseguranza

Group Number____________________________ID#__________________________________
Numero de Grupo No de Identificacion de Aseguranza

Subscriber
Name_________________________________Birthdate__________________________________
Nombre del Asegurado Fecha de Nacimiento

Subscriber Address ____
If different from patient
Direccion del asegurado si diferente a la del paciente

Subscriber Phone:___________________________Relationship to Insured___________________
Telefono del Asegurador Relacion con el asegurador

Copay Amount:______________________
Co pago

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New Spine Patient Information Form

Welcome to the Napa Valley Orthopaedic Medical Group, Inc.
Please take a few moments to assist us in gathering information about your spine ailment by completing the following form. If you require more space please make a note of it and we will discuss it in more detail during your visit.

Name:____

Question		Answer
What part of your body is bothering you?		
How old are you?		
How tall are you?		
How much do you weigh?		
When did this problem start?		
How did this problem begin?		
How often does this problem bother you? (every day, once a week, several times a year…)		
When this problem is bothering you is it constant or does it come and go?		
From 1-10 rate your pain:		1 2 3 4 5 6 7 8 9 10
Describe your pain e.g. sharp, burning, achy, deep, dull:		
Does your pain radiate to another part of your body? If so where?		
What makes your symptoms better?		
What makes your symptoms worse?		
Do your symptoms disturb your sleep? How?		
What time of the day are your symptoms the worst?		
Have you seen a therapist, chiropractor or other practitioner for this problem? Did it help?		
Have you had any injections or surgery for this problem? If so when and did it help?		
Do you take medications for this problem? If so what medications and do they help?		

Medical History:

Please list any **medical problems** that you have, even if they are under control.

1	7
2	8
3	9
4	10
5	11
6	12

Please list any **surgeries** you have had.

1	7
2	8
3	9
4	10
5	11
6	12

Please list any **allergies** you have to medications or other significant allergies.

1	3
2	4

Please list your current **medications** (if you have a list, bring it to the receptionist to copy)

1	6
2	7
3	8
4	9
5	10
Please List your pharmacy name and number	

Please list any major medical problems that run in you **family**.

Relative	**Disorder/Disease**	**Disorder/Disease**
Mother		
Father		
Brothers/Sisters		
Other Family Members		

Social History:

Do you smoke?	
How many packs a day?	
How long have you smoked?	
Do you use other tobacco products?	
Do you drink alcohol?	
How many drinks do you have a day?	
Do you use any other drugs?	
What is your marital status:	
What is the highest level of education you have completed?	
Do you exercise?	
What are your hobbies?	

Review of Systems:

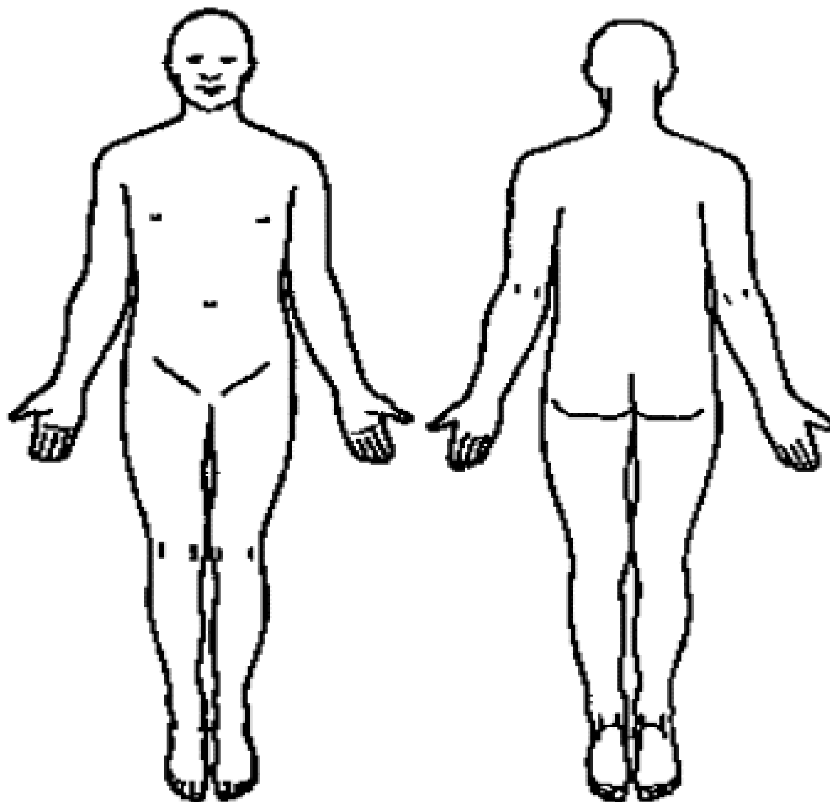
Do you have any of the following symptoms?

Category	**Symptom**	**Yes**	**No**
General	Fever		
	Chills		
	Recent weight loss		
	Recent weight gain		
	history of cancer		
Eyes	Glasses		
	Double Vision		
	Blurry Vision		
	Recent Changes in Vision		
ENT	Hearing Loss		
	Difficulty Swallowing		
	Change in Voice		
	Sinus Infections		
Respiratory	Asthma		
	Emphysema		
	Shortness of Breath		
GI	Acid Reflux		
	Stomach Pain		
	Stomach Ulcers		
	GI Bleeding		
	Liver Problems		
	Hepatitis		
GU	Bladder Infections		
	Difficulty Urinating		
	Loss of Urinary Continence		

Category	**Symptom**	**Yes**	**No**
Musculoskeletal	Joint Pain		
	Joint Swelling		
	Weakness		
Skin	Rashes		
	Recent Cuts		
Neurologic	Loss of Balance		
	Loss of Coordination		
	Numbness		
	Weakness		
	Strokes		
	Seizure		
Psychiatric	Depression		
	Anxiety		
Hematological	Blood Clots		
	Bleeding Problems		
	Immune Disorder		
	HIV/AIDS		
Endocrine	Diabetes		

Pain Diagram

On the diagram please draw where your symptoms are:



Thank you for taking the time to fill out this form.

Napa Valley Orthopaedic Medical Group, Inc.

CONSENT FOR TREATMENT

Adult

I hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

OR

Complete for a Minor

I certify that I am a legal guardian of ___________________________, a minor, and I do hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

INSURANCE ASSIGNMENT

I give permission to Napa Valley Orthopaedic Medical Group, Inc. to bill my insurance carrier for services rendered. I understand that this is a service provided by Napa Valley Orthopaedic Medical Group, Inc. I request that payment of authorized Medicare or other insurance company benefits be made directly to Napa Valley Orthopaedic Medical Group, Inc., otherwise payable to me, for any services furnished to me by Napa Valley Orthopaedic Medical Group, Inc. Regulations pertaining to Medicare assignment of benefits apply.

I permit a copy of this authorization to be used in place of the original. I understand that I must inform my physician if I know that a party other than Medicare is responsible for paying for my treatment.

I understand that I am responsible for my medical bills unless I have verified coverage under an active Worker's Compensation claim. I hereby guarantee payment of all physician/provider charges and understand that any amount not paid by insurance within 60 days of service becomes my personal responsibility unless my injury is covered under an active Worker's Compensation claim. Examples of this would include but not be limited to any coinsurance, deductibles, and copayments.

INFORMATION RELEASE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance, information needed for this or a related Medicare or other insurance company claim. I understand that my

signature requests that payment be made and authorizes release of any medical or other information necessary to pay the claim.

PAYMENT POLICY

It has been explained to me that if I am paying privately for medical treatment, payment of all charges is to be made in full at the time of service unless previous arrangements have been made, and I agree to pay all the charges.

If there is a co-payment for the medical service, I understand that it is due at the time of service, and I agree to make this payment.

I have carefully read and agree to the above information.

Signature: ______________________________________ *Date:* ________________

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HEALTH INSURANCE PORTABILTY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy (5 pages) of the Napa Valley Orthopaedic Medical Group, Inc. Notice of Privacy Practices. This Notice describes how Napa Valley Orthopaedic Medical Group, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

Name: ______________________________

Signature: __________________________

Date: ______________________________

I have been given an opportunity to take a copy of the Napa Valley Orthopaedic Medical Group, Inc. Notice of Privacy Practices to review and hereby voluntarily decline to take a copy for my own review. I have been made aware that Napa Valley Orthopaedic Medical Group, Inc. functions under the guidelines of the Health Insurance Portability and Accountability Act (HIPAA), but do not wish a hard copy of the policy at this time.

Name:______________________________

Signature: __________________________

Date: ______________________________