



DISC & SPINE

PATIENT REGISTRATION FORM

1

RR VT

PATIENT NAME: _____

DATE OF BIRTH: _____ Social Security #: _____ Male Female

MARITAL STATUS: Single Married Other (please specify): _____

Race/Ethnicity: _____ Primary Language: _____

Mailing Address: _____ Apt/Suite #: _____

City _____ State _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred: Home Cell Work

Email Address: _____

PRIMARY CARE PHYSICIAN: _____ Phone No.: _____

REFERRED BY: _____

EMPLOYMENT:

Employer's Business Name: _____ Occupation: _____

Current Status: Full-time Part-time Seasonal Retired Unemployed Student

RESPONSIBLE PARTY INFORMATION:

Complete if patient is 17 or younger. Any legal guardian/parent presenting a minor patient for medical services is considered financially responsible for services rendered. Any minor patient accompanied by an adult other than their legal guardian/parent must present written and notarized authorization for medical treatment from the legal guardian/parent prior to services being rendered.

Full Name: _____ Social Security #: _____

Relation to patient: _____ Date of Birth: _____

Address (if different from above): _____

Phone Number: _____ Employer: _____

EMERGENCY CONTACT (if different from above):

Full Name: _____ Relation to patient: _____

Phone Number: _____ City, State: _____

HOW WILL THE SERVICE BE PAID?

Private Insurance Worker's Compensation Self-pay (NO Insurance)

OTHER (need complete documents): _____

Patient Signature: _____

Today's Date: _____

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INSURANCE INFORMATION

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FULL NAME: _____

PRIMARY INSURANCE:

Insurance Company Name: _____ PPO HMO EPO

Address: _____

Subscriber's ID #: _____ Policy or Group #: _____

• **If Policyholder/Subscriber for Primary Insurance is different from patient, please answer below.**

Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____ Phone: _____

Complete Address: _____

Employer (if issued through employment): _____

SECONDARY INSURANCE:

Insurance Company Name: _____ PPO HMO EPO

Address: _____

Subscriber's ID #: _____ Policy or Group #: _____

• **If Policyholder/Subscriber for Secondary Insurance is different from patient, please answer below.**

Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____ Phone: _____

Complete Address: _____

Employer (if issued through employment): _____

DO YOU HAVE AN ATTORNEY? YES NO

If YES, who? _____ Phone Number: _____

Address: _____ Which Law Firm? _____

WORK RELATED INJURIES:

Date of Injury: _____ Claim Number: _____

Worker's Compensation Carrier: _____

Address: _____

Claim Adjuster's Name: _____ Phone Number: _____

FAX: _____ Email Address: _____

Employer at time of Injury: _____

Supervisor's Name: _____ Phone Number: _____

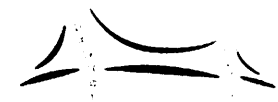
Patient/Guardian Signature: _____

Today's Date: _____

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Patient Medical History



FULL NAME: _____ DATE: _____

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DOB: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

Primary Care Physician: _____ Referred by: _____

CHIEF COMPLAINT: _____ Pain Level (1-10): _____

Was this MVA related? _____ Work-related Injury? _____ Date of Onset: _____

Previous TREATMENT: Physical Therapy Chiropractor Accupuncture Medications
 Massage Treatment Epidural Injections/Other: _____

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES
 Local Anesthesia Narcotics NSAIDs Penicillin Other: _____

MEDICINE:

(Please list any medications or supplements that you take REGULARLY including dosage and frequency.)

Name of Drug	Dosage	Purpose	Doctor

PRIOR SURGERY:

	Name of Operation	Why	When	Where	Surgeon
1					
2					
3					

PERSONAL ILLNESSES:

FAMILY MEDICAL HISTORY:

Health Issues:	YES	NO	Health Issues:	YES	NO
Cancer			Cancer		
Heart Disease			Heart Disease		
Stroke			Stroke		
Hypertension (HBP)			Hypertension (HBP)		
High Cholesterol			High Cholesterol		
Diabetes			Diabetes		
OTHER:			OTHER:		

SOCIAL HISTORY:

Occupation: _____ Employer: _____ Still Employed? _____

Marital Status: _____ Lives with: _____ Birth place: _____

Do you smoke? Yes No Quit: _____

Do you drink alcohol? Yes No

Name: _____

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REVIEW OF SYSTEMS:

Please answer Yes, if you experienced any of the following in the *last few weeks or months*. If you have no recent complaints, please check: NONE

GENERAL

Fatigue Yes
 Decreased appetite Yes
 Fevers Yes
 Weight loss Yes
 Weight gain Yes
 Insomnia Yes
 Do you have a living will Yes
 Do you smoke Yes
 Do you drink alcohol Yes
 Are you in pain 1-10 Yes

EYES, EARS, NOSE and THROAT

Visual changes Yes
 Hearing loss Yes
 Sore throat Yes
 Nasal Congestion Yes
 Runny nose Yes
 Ear Pain Yes

NECK

Swollen Glands Yes

RESPIRATORY

Shortness of breath Yes
 Cough Yes
 Wheezing Yes

CARDIOVASCULAR

Chest pain Yes
 Palpitations Yes
 High blood pressure Yes
 Stroke Yes

DIABETES

A1C Results Yes
 Blood Sugars Yes
 CGM – Sensor Problems Yes
 CGM – Sensor Readings Yes
 Digestion problems Yes
 Labs Yes
 Lipids Yes
 Loss of consciousness Yes
 Medications Yes
 Meter Problems Yes
 Meter Readings Yes
 Pump Problems Yes
 Pump Settings Yes
 Sores on feet Yes
 Tingling/numbness –Feet Yes

GASTROINTESTINAL

Abdominal pain Yes
 Constipation Yes
 Bloody stool Yes
 Diarrhea Yes
 Heartburn Yes
 Nausca/Vomiting Yes

GENITOURINARY

Change in bowel habits Yes
 Painful urination Yes
 Bloody urine Yes
 Increased urination Yes
 Leaking Urine Yes
 Erectile Dvsfunction Yes

GYNECOLOGIC

Irregular Menses Yes
 Abn. Vaginal Discharge Yes
 Pelvic Pain Yes
 Pain with intercourse Yes
 Painful Menses Yes
 Pregnant Yes

SKIN

Rashes Yes
 Itching Yes
 Mole Changes Yes

MUSCULOSKELETAL

Joint pain Yes Where?
 Muscle pain Yes Where?
 Leg swelling Yes Where?

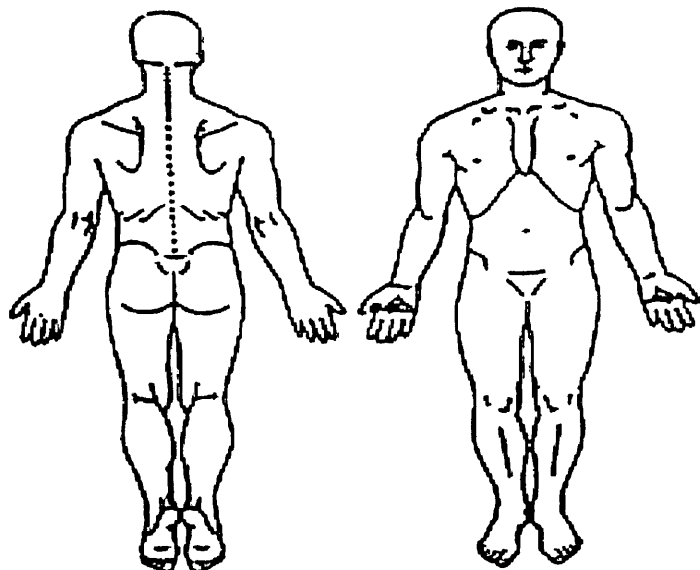
NEUROLOGIC

Headaches Yes
 Dizziness Yes
 Difficulty walking Yes
 Numbness or tingling Yes

PSYCHIATRIC

Anxiety Yes
 Irritability Yes
 Sexual Problems Yes
 Suicidal Ideation Yes
 Depression Yes
 Concerns about your emotional or physical safety? Yes

Please mark with an X where you are experiencing pain.



Are you pregnant? Yes No
 If yes, date of delivery? _____

Have you had blood transfusion previously?
 Yes No

Patient's Signature: _____

Date: _____

Physician's Signature: _____

Date: _____



DISC & SPINE

1320 El Capitan Drive #200
Danville, CA 94526
Phone: (925)275-0700
Fax: (925)275-0701

Robert A. Rovner, MD
A PROFESSIONAL CORPORATION
Diplomate American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgery

Vikram Talwar, MD, INC
Diplomate American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgery

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Patient Name: _____ Birthdate: _____

I understand that as part of my healthcare, Dr. Rovner and Dr. Talwar originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please refer to the "Privacy Policy" Brochure, refer to the "Request Restrictions section. This brochure is available in the office upon request.

Please answer the following 3 questions:
I request the following restrictions to use or disclose of my health information:

<p>1) Medical Information can be discussed with:</p> <p><input type="checkbox"/> Patient Only</p> <p><input type="checkbox"/> Family Member or Friend -Please list Name/Relationship</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Physician: _____</p> <p><input type="checkbox"/> Attorney: _____</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> No Restrictions</p>	<p>2) Detailed messages regarding test results can be left on answering machine</p> <p><input type="checkbox"/> Yes Phone Number: _____</p> <p><input type="checkbox"/> No</p>
<p>3) Please choose how you would like to receive the reminder:</p> <p><input type="checkbox"/> Automated voice message</p> <p><input type="checkbox"/> E-mail</p> <p><input type="checkbox"/> Text</p> <p><input type="checkbox"/> None of the above</p>	

Signature of Patient or Legal Representative:

Relationship to Patient: _____

_____ Date _____ Witness _____



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Danville, California 94526
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Patient Name: _____ **Date of Birth:** _____

Financial Policies

Assignment of Benefits and Release of Information I hereby assign insurance benefits to be paid directly to Dr. Rovner or Dr. Talwar for medical and surgical services rendered to me. I hereby authorize the release of medical information to insurance carriers.

Patient Responsibility (with medical insurance coverage) I understand that I am financially responsible for charges not covered by my insurance benefits, workers compensation carrier, or liability insurance. Office visit co-payment is due and payable at time of service.

Patient Responsibility (self-pay patients) I understand payment for all services are due at the time services are rendered.

Financial Guarantee I guarantee that in consideration of services rendered by the physicians, Dr. Rovner or Dr. Talwar, I will be personally responsible for any and all expenses incurred for such treatment. Also, I agree to pay all collection agency fees, attorney's fees, and court costs.

Credit Card Information We accept the following credit cards: Visa MasterCard, Discover, or American Express. Debit cards are accepted for all banks. The minimum charge amount for American Express is \$20.00.

No-Show Policy There will be a **\$40.00** No-Show charge assessed for appointments that are not cancelled within a 24-hour period prior to the appointment date/time.

Form Fee Policy I am aware that there is a **\$25.00** fee for the completion of all forms except State of California Employment Development Department (disability). This fee is due before the completion and release of the form to me.

Non-Sufficient Fund (NSF) Policy I acknowledge that there is a **\$25.00** bank and processing fee in addition to the original check amount that will be assessed.

Preferred Provider Plans With certain insurance companies, it is necessary for you to be treated by a Preferred Provider to ensure complete coverage. If the doctor is not on the preferred provider panel, you will be responsible for the charges. Please check with your insurance carrier or our office for verification before being seen.

Medicare We accept assignment with Medicare. One secondary insurance claim is submitted as a courtesy.

Non-Contracted Plans and/or Motor Vehicle Claims We will submit one insurance claim as a courtesy, provided that a current insurance card is presented at your visit OR we have proof of your personal injury coverage.

Third Party Claims We do not bill third party claims.

HMO Insurance Plans A referral is required from your primary care physician prior to each appointment. If we do not have a referral at the time of your appointment, your signature/initials acknowledge that you will be responsible for any charges incurred without a referral/authorization.

Durable Medical Equipment During your visit, durable medical equipment such as neck or back braces may be ordered and dispensed. If you have health insurance, those items will be pre-authorized prior to being dispensed. These charges may be reflected on your statement.

Signature of Patient or Guarantor:

Date: _____

Print Patient Name:
