DISC & SPINE

Comprehensive Care of the Cervical & Lumbar Spine
Microsurgery of the Spine
Scoliosis & Spine Deformity Treatment

Robert A. Rovner, MD, MBA
A Professional Corporation

Vikram Talwar, MD
Incorporated

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Dear New Patient,

I would like to personally welcome you to my practice.

My area of specialty is orthopedic spine surgery. I have done a residency in general orthopedics (fractures, joint replacements, hand surgery, etc.) with additional training in spine surgery. In addition I have worked on trauma of the spine, tumors, scoliosis and degenerative conditions. For the past ten years I have been working with patients in the Tri-Valley area.

Even though I am a surgeon, this does not mean that everyone I see is a candidate for surgery. Once you see me, I hope to give you a good understanding of what is wrong with your neck, low back or mid back. Together we can come up with a specific plan tailored for you and your spine issue. I prefer to start off with being conservative and non-invasive, if at all possible. Conservative treatment may include medications, physical therapy, acupuncture, chiropractic treatment and other modalities. However, if this type of treatment is not working for you, then we can consider injections or possibly surgery.

When you come into my office, I would like you to bring any important information about your back or neck. This includes the medical history of any past treatment.

1. Bring your films. MRIs, CAT scans and x-rays are very important. I prefer to view the actual images on film or CD, but the radiologist's written report is helpful to me as well.

2. Have you had any injections? If so, please be able to tell me what type of injection and the name of the physician who performed your procedure. I will also want to know how you reacted to the injection. Did it help? How long did it last?

3. If you have had spine surgery (on the body part you want me to evaluate), please provide me a copy of the operative report.

4. Bring a list of your current medications.

Please feel free to bring a family member or friend to your appointment as they may also have questions. You may also want to write down some questions for me prior to our appointment to help guide our conversation and to help us develop a great treatment plan for you.

I look forward to meeting you and working together with you.

Sincerely,

Vikram Talwar, M.D.

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PATIENT REGISTRATION FORM

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

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

Name______________________________ **DOB:**__________ **Age**_________ **Todays Date**__________________

Primary Care Doctor_____________________ **Referring Doctor**________________ **Height**_______ **Weight**_______

Drug Allergies: (Please indicate by checking the boxes below.)

☐ NO KNOWN DRUG ALLERGIES

☐ Local anesthetics (Novocain etc.) ☐ Penicillin ☐ Keflex ☐ Erythromycin ☐ Other antibiotic: ______________________

☐ Sulfa drugs ☐ Aspirin ☐ Narcotics (codeine, morphine etc.) ☐ Other painkillers (Percocet, Oxycontin etc.)

☐ Latex ☐ Eggs/Yolk ☐ Sulfites ☐ Tetracycline ☐ Iodine/shellfish ☐ NSAIDs (Ibuprofen etc.)

Please specify any others: ____

Please specify type of reaction: ____

Medicines: (Please list any medications or supplements that you take **REGULARLY**, with dose/frequency.)

1.__________________________ 2.__________________________ 3.__________________________

4.__________________________ 5.__________________________ 6.__________________________

Social History:

Occupation____Employer______________________________

Marital Status ____________________________

Lives with (check all that apply):

☐ Spouse ☐ Children ☐ Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Foster Care ☐ Roommates

Social Habits: **(It is now required that we ask the below information)**

Tobacco - Do you smoke or use tobacco products?__________ Check all that apply: ☐ Cigarettes ☐ Cigars ☐Chewing ☐Tobacco

How much?__________/day. Number of Years using _______ If you quit, when?______________________________

Recreational Drugs – Do you use recreational/illicit drugs?___________ Which drugs? _________________________

Alcohol- Do you use alcohol? ☐YES ☐NO How much?_______/week. If you quit, when?___________________________

Exercise- Do you exercise on a regular basis? ☐Yes ☐No Type of Exercise: ____________________________

Times per week: _______________

Review of Systems: Have you experienced any of the following in the **last few weeks or months**?

Please check the complaint and detail below. If you have no complaints in a category, please check: ☐ NONE

General:
- ☐ Fever
- ☐ Chill
- ☐ Sweats
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Weight Loss
- ☐ Weight Gain

Cardiovascular:
- ☐ Chest Pains
- ☐ Fainting
- ☐ Leg Swelling
- ☐ Shortness of Breath
- ☐ Murmur

Respiratory:
- ☐ Cough
- ☐ Cold
- ☐ Wheezing
- ☐ Painful Breathing
- ☐ Tuberculosis
- ☐ Cough

Eyes/Ears/Nose/Throat
- ☐ Glasses
- ☐ Contacts
- ☐ Double vision
- ☐ Impaired Hearing
- ☐ Nosebleeds
- ☐ Sneezing
- ☐ Runny Nose
- ☐ Dentures
- ☐ Dizziness

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Loose Stools
- ☐ Blood in Stools
- ☐ Abdominal Pain

Skin:
- ☐ Open Sores
- ☐ Boils
- ☐ Wound Breakdown
- ☐ Tender Spots
- ☐ Rash

Neurologic:
- ☐ Weakness
- ☐ Numbness
- ☐ Paralysis
- ☐ Loss of Consciousness
- ☐ Headache
- ☐ Tremor
- ☐ Slurred Speech

Genitourinary:
- ☐ Urine Incontinence
- ☐ Urinary Frequency
- ☐ Blood in Urine

Endocrine:
- ☐ Fatigue
- ☐ Hyperactivity
- ☐ Excessive Thirst

Heme/Lymphatic:
- ☐ Bruising
- ☐ Bleeding
- ☐ Lymph Node Swelling

Allergic/Immunologic:
- ☐ Hives
- ☐ Persistent Infections
- ☐ HIV Exposure
- ☐ Past Blood Transfusion

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Mood Swings

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness

*Other:*____

____

Pregnancy- Estimated Due Date:____________________

Previous Problems:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Depression
- ☐ Diabetes, Mellitus
- ☐ Esophageal
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Osteoarthritis
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Pneumonia

Family Medical History:

- ☐ Patient denies any significant Family History
- ☐ Anesthesia/Surgical Complications
- ☐ Asthma/Breathing Problems
- ☐ Bleeding Disorders
- ☐ Blood Clots/Phlebitis
- ☐ Cancer
- ☐ Connective Tissue Disorder
- ☐ COPD Chronic Obstruction Pulmonary Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Disease/Heart Attack/Chest Pain
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Strokes/transient Ischemic Attacks (TIA)
- ☐ Thyroid disease

* ***Have you or a family member ever been diagnosed with a blood clot in a leg or a lung?*** ☐YES ☐NO

If "Yes", who had the clot? ____________________

Are you under the care of a Cardiologist: ☐ **Yes** ☐**No** **Name:** ______________________________

Contact Info: ____________________

Have you ever had problems with Anesthesia in the past?

If yes, please explain: ____

Previous Hospitalizations?

____

____

Please list Surgeries/Complications/Diagnoses along with the DATE.

Surgery	**Year**	**Complications**
1.		
2.		
3.		
4.		
5.		

Have you had an Influenza shot this year? ☐ YES ☐ NO

If over 65 years old: Have you had a Pneumovax vaccination? ☐ YES ☐ NO

For future office visits: Have there been any changes to your personal information, allergies, medications or surgical history?

☐ **NO** ☐ **YES (explain)** ______________________________ **Date:**________ **initial:**______

☐ **NO** ☐ **YES (explain)** ______________________________ **Date:**________ **initial:**______

☐ **NO** ☐ **YES (explain)** ______________________________ **Date:**________ **initial:**______

Patient Signature:______________________________**Date:**____________________

MD/PA:______________________________**Date:**____________________

Patient Name:______________________

Date:______________________

HISTORY OF PROBLEM

Please explain briefly why you are seeing the doctor: ☐Left ☐Right______________________

____

First Symptom or Date of Injury:______________________

How did the injury occur and when?______________________

Was an automobile involved:

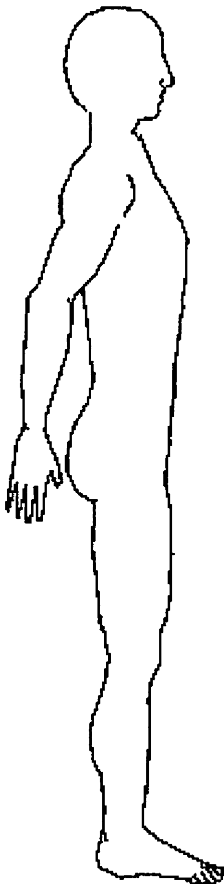
☐ YES ☐ NO Date of accident:______________________

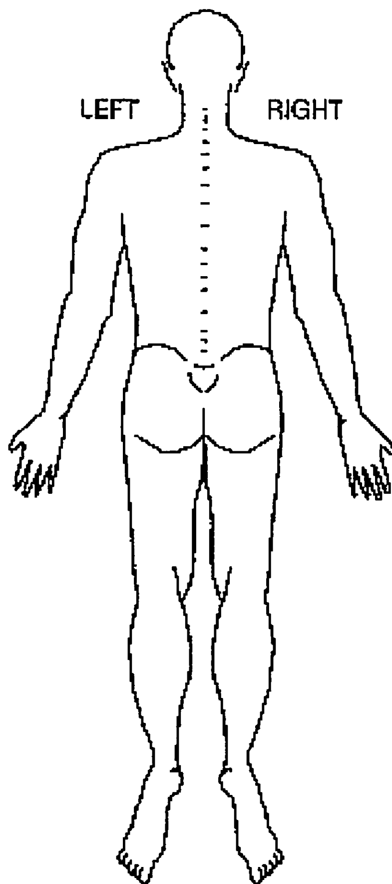
Name of Attorney:______________________ Phone:______________________

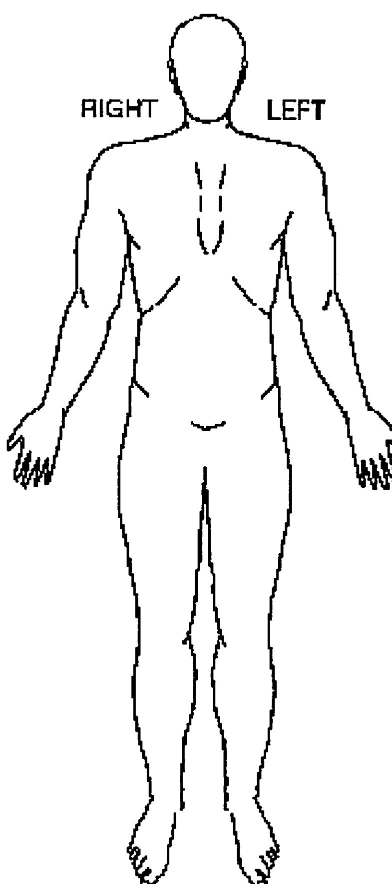
Was this Injury at work?

☐ YES ☐ NO

PLEASE MARK WITH AN X WHERE YOU ARE EXPERIENCING PAIN







Pain level: Please Circle: 0 1 2 3 4 5 6 7 8 9 10

none worst

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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:

1) Medical Information can be discussed with:
- ☐ Patient Only
- ☐ Family Member or Friend
  -Please list Name/Relationship
  ____
  ____
  ____
- ☐ Physician: ______________
- ☐ Attorney: ______________
- ☐ Other: ______________
- ☐ No Restrictions

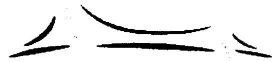
2) Detailed messages regarding test results can be left on answering machine
- ☐ Yes Phone Number: ____________
- ☐ No

3) Please choose how you would like to receive the reminder:
- ☐ Automated voice message
- ☐ E-mail
- ☐ Text
- ☐ None of the above

Signature of Patient or Legal Representative:

______________________ ______________ ______________
Date Witness

Relationship to Patient: ______________________



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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:

____