ROBERT A. ROVNER, MD

A PROFESSIONAL CORPORATION

Fellow American Board of Orthopedic Surgery

American Academy of Orthopedic Surgery

PATIENT REGISTRATION FORM

Patient Name (First, Middle, Last): _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other:_____

Marital Status:☐ Single ☐ Married ☐ Other (*please specify*): _____

Primary Language: _____

Mailing Address: _____ Apt/Suite #: _____

City _____ State _____ Zip code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Text Appt. Confirmation: □ YES □ NO

Email Address: _____ Email Appt. Confirmation: □ YES □ NO

Preferred Method of Contact: □ Home □ Cell □ Work

PRIMARY CARE PHYSICIAN: _____ **Phone No.:** _____

REFERRED BY: _____

EMPLOYMENT:

Employer's Business Name: _____Occupation: _____

Current Employment Status (Full-Time, Part Time, Student, Unemployed, Retired…): _____

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: _____Relation to patient: _____ Date of Birth: _____

Address (if different from above): _____

Phone Number: _____ Employer: _____

EMERGENCY CONTACT: *Are we authorized to speak to your emergency contact regarding your medical record and treatment?* ☐ YES ☐ NO

Full Name: _____ Relation to patient: _____

Phone Number: _____ City, State: _____

INSURANCE INFORMATION

HOW WILL THE SERVICE BE PAID?

☐ Private Insurance ☐ Self-pay (NO Insurance) ☐ MVA (self-pay) Date of accident:_____

☐ Other (need complete documents): _____

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: _____ 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 Primary Insurance is different from patient, please answer below.*

Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone: _____

Complete Address:_____

Employer (*if issued through employment*): _____

Patient/Guardian Signature: _____Today's Date: _____

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NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name:_____ Date of Birth:_____ Age:_____

Height: _____ Weight:_____

What is the reason for your visit today/ chief complaint?

Do you need a work note or forms completed (if so, what note/form)?

Pain level today (1-10):_____

Treatment Related to Current Problem

	YES	NO	Number of Visits	Year
Physical Therapy				
Chiropractic				
Acupuncture				
Injections				

-Type(i.e epidural, facet, ablation):

Medications for injury: ***Please List***				
Brace				
Home Exercise Program				
Surgery				

How often does the pain/numbness occur:☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent ☐ N/A

What is the status of your condition since the onset date:
☐ Unchanged ☐Improving ☐Fluctuating ☐Stable ☐Worse ☐ Resolved

Where type of pain/ numbness are you experiencing? Check all that apply ☐ No pain/numbness
☐ Ache ☐ Burning ☐ Deep ☐ Superficial ☐ Dull ☐ Localized ☐ Piercing ☐
Sharp ☐Shooting ☐ Throbbing ☐ Electric ☐ Tingling ☐ Numb ☐ Discomfort

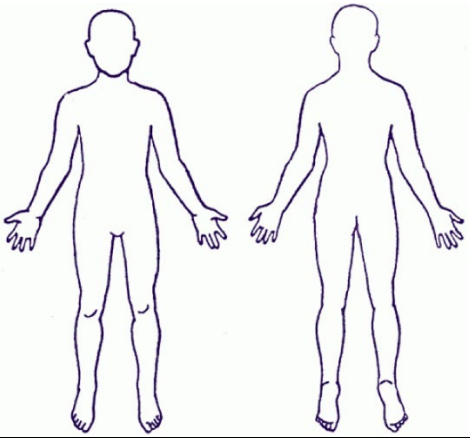
What is the location of your pain/numbness? Check all that apply ☐ No pain/numbness

☐ Neck	☐ Upper back	☐ Mid back	☐ Lower back	☐ Gluteal area	☐ Flank
☐ Thighs	☐ Legs	☐ Shoulder	☐Arm	☐ Hand	☐ Fingers
☐ Other:_____	(circle one) RT / LT / Both	(circle one) RT / LT / Both	(circle one) RT / LT / Both	(circle one) RT / LT / Both	(circle one) RT / LT / Both

Patient Name: _____ Date of Birth:_____

Below "X" the areas you feel pain

FRONT **BACK**



Circle which best describes your pain:

What aggravates your condition? Check all that apply ☐ Nothing aggravates my condition

☐ Daily activity ☐ Ascending stairs ☐ Descending stairs ☐Coughing ☐ Driving

☐ Flexion ☐ Extension ☐ Lifting weight ☐ Rotating/twisting ☐ Bending ☐ Standing

☐ Sitting ☐ Walking ☐ Exercise ☐ Lying down/sleep ☐ Other:_____

What relieves your condition? Check all that apply ☐ Nothing relieves my condition

☐ Ice ☐ Heat ☐ Elevation ☐Mobility ☐ Rest ☐ Stretching ☐ Exercise ☐ Brace

☐ Massage ☐ Physical therapy (how many visits completed):_____ ☐ Acupuncture ☐ Chiropractic

☐ Injection ☐ OTC meds (which med):_____

☐ Pain medication (which med):_____

Pain level after taking your medication: No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC/vitamins/herbals/supplements)

☐ **No medications to list**

☐ See attached medications list

Are you taking blood thinners? ☐ Yes ☐ No

Medication	Dosage & Frequency	Purpose & Administered route i.e. oral/IV/topical	Physician

DRUG & OTHER ALLERGIES (list):

☐ NO KNOWN DRUG ALLERGIES

Patient Name: _____ Date of Birth:_____

Have you had a fall in the last 12 months? ☐Yes ☐ No More than 2 times? ☐Yes ☐ No

SOCIAL HISTORY

Do you smoke tobacco products? ☐Yes ☐ No If yes, have you ever tried to quit? ☐Yes ☐ No
Type:_____ Packs per day:_____ Years used:_____
Do you drink alcohol? ☐Yes☐ No If yes, how many drinks per week?_____
Do you presently use any recreational drugs? ☐Yes☐ No If so, please list: _____
Have you traveled or lived outside the US or Canada? ☐Yes☐ No
If yes, when/where:_____

PAST MEDICAL AND FAMILY HISTORY

Illness/Condition	Self	Relative	Describe
Anesthesia complications	☐Yes ☐No	☐Yes ☐ No	
Bleeding prob/blood clots	☐Yes ☐No	☐Yes ☐ No	
Cancer	☐Yes ☐ No	☐Yes ☐ No	
Diabetes	☐Yes ☐ No	☐Yes ☐ No	
Heart disease	☐Yes ☐ No	☐Yes ☐ No	
Hepatitis/HIV	☐Yes ☐ No	☐Yes ☐ No	
High Blood Pressure	☐Yes ☐ No	☐Yes ☐ No	
Liver disease	☐Yes ☐ No	☐Yes ☐ No	
Psychiatric illness	☐Yes ☐ No	☐Yes ☐ No	
Stroke/TIA	☐Yes ☐ No	☐Yes ☐ No	
Tuberculosis	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

Do you have a chronic illness ☐Yes ☐ No If yes, what is it:

DIAGNOSTIC HISTORY ☐ None

Study	Within 6 months	Within 1 year	Body Part
X-rays	☐Yes ☐ No	☐Yes ☐ No	
MRI/CT	☐Yes ☐ No	☐Yes ☐ No	
EMG/nerve conduction studies	☐Yes ☐ No	☐Yes ☐ No	
Myelogram	☐Yes ☐ No	☐Yes ☐ No	
Bone scan/DEXAscan	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

PRIOR SURGERY ☐ None

Name of Operation	Reason	Date	Facility	Physician

Patient Name: _____ Date of Birth:_____

REVIEW OF SYSTEMS

CHECK IF YOU HAVE ANY OF THE FOLLOWING

Constitutional	Cardiovascular	Integumentary	Ear, Nose, Throat & Eyes
☐ Fever/chills/night sweats	☐ Stroke/blood clots	☐ Rash	☐ Eye/vision disorders
☐ Weakness/fatigue	☐ Chest pain	☐ Skin infections	☐ Frequent sore throat
☐ Weight gain	☐ Abnormal heart rhythm	☐ Skin lesions	☐ Vertigo/dizziness
☐ Weight loss	☐ High blood pressure	☐ Other: _____	☐ Voice hoarseness
☐ Other:_____	☐ Heart problem:_____		☐ Difficulty swallowing
	☐ Other:_____		☐ Other: _____

Gastrointestinal (GI)	Neurological	Respiratory	Genitourinary
☐ Constipation/diarrhea	☐ Diff. walking/balance	☐ Lung issues:_____	☐ Kidney stones
☐ Liver/gallbladder issues	☐ Dizziness	☐ Recent cold/flu	☐ Frequent urination
☐ Nausea/vomiting	☐ Seizures	☐ Wheezing/asthma	☐ Blood in urine
☐ Ulcers	☐ Headache	☐ Coughing blood	☐ Kidney disease
☐ Heartburn/reflux	☐ Weakness/numbness	☐ Shortness of breath	☐ Bladder leakage
☐ Black or bloody stool	☐ Neurologic problem	☐ Abnormal chest x-ray	☐ Other: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	

Psychiatric	Allergic/Immunologic	Musculoskeletal	Endocrine
☐ Anxiety	☐ Rheumatoid arthritis	☐ Arthritis/osteoporosis	☐ Diabetes – I or II
☐ Depression	☐ Lupus	☐ Broken bones	☐ Parathyroid/Paget's
☐ Insomnia	☐ Hives/Eczema	☐ Joint pain/swelling	☐ Heat/cold intolerance
☐ Mood disorder	☐ Autoimmune disorder	☐ Carpal tunnel	☐ Thyroid disorder ☐
Other:_____	☐ Other:_____	☐ Other:_____	☐ Other:_____

Hematology/Lymphatic	Females Only	Other:
☐ Easy bruising/bleeding	☐ Pregnant	
☐ Enlarged glands	☐ Last menstrual period:	
☐ Anemia	_____	
☐ Blood transfusions		☐ ALL NEGATIVE
☐ Other:_____		

Office use:

Pulse:_____ BP:_____ BMI:_____

General Appearance: ☐ Well nourished ☐ Not well nourished ☐ Stand Normally ☐ Doesn't stand normally

Oriented x 3: ☐ Awake ☐ Responsive ☐ Oriented of person/place/time

Mood and Affect: ☐ Normal ☐ Not Normal

_____ _____

Patient Signature **(Date)** **Provider Signature** **(Date)**

Disc and Spine a partnership of

Robert A. Rovner MD, A Professional Corporation and Vikram Talwar MD Incorporated

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Your Health Information

We understand that information about you and your health is personal. We are both committed to, and required by law to, maintain the privacy of this information. Each time we provide services, we create a record of the care and services you receive. We need this record to provide quality care and to comply with certain legal requirements. This notice applies to all of your information and the records of your health care generated by us or received by us from you or others.

Along with safeguarding your personal health information, we must also make available this notice of our legal duties and privacy practices, and we must follow the terms of the notice currently in effect. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights of access, amendment, control, and other rights concerning the use and disclosure of your health information. Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. is also required to notify you if your health information is breached.

If you are the parent, legal guardian, or personal representative of the patient, the references herein such as "...your personal health information..." shall be understood to refer to that patient.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us, directly to our Privacy Officer: Vanessa Chaplin, Disc and Spine, 1320 El Capitan Drive, Suite 200, Danville CA 94526, Phone: (925)275-0700, Fax: (925)275-0701 You can also file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov or in writing to any regional HHS office. There will be no retaliation for filing a complaint.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we may USE your health information within Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc., and DISCLOSE your health information to persons and entities outside of Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. We have not listed every use or disclosure within the categories, but give some examples for understanding.

Common Uses and Disclosures Allowed by Law

Treatment: We may use your health information to provide you treatment and services. We may disclose health information about you to others who are involved in your care.

Payment: We may use and disclose your health information so the treatment and services you receive at Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. may be billed to and payment collected from you, an insurance company or a third party. We may also disclose health information to your insurance plan to obtain prior authorization for treatment and procedures.

Health Care Operations: We may use and disclose your health information for health care activities such as: quality assurance; administration; Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. financial and business planning and development; and customer service (including investigation of complaints). These uses and disclosures are necessary to operate our health care facility and make sure patients receive quality care.

Business Associates: Some services may be provided to our organization through contracts with business associates, such as: practice consultants; quality assurance reviewers; and billing and transcription services. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. Business associates are required, both legally and contractually, to appropriately safeguard your information.

Contacting You About Your Health: We may use and disclose health information to contact you, such as a reminder about an appointment or other treatment options at Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc.

Fundraising: If we are going to contact you as part of a fundraising effort, you will have a simple way to opt out of these contacts.

Individuals Involved in Your Care: We may disclose health information about you to a friend or family member who is involved in your care, unless you tell us in advance not to do so.

Other Laws: At times there may be federal, state or local laws that require us to use or disclose health information in other ways, or give you additional privacy protections. We will obey those laws.

Certain Situations Do Not Require Your Authorization

The following disclosures of your health information are permitted by law without any oral or written permission from you:

Public Health Activities: We may disclose health information about you for public health activities, including:

* To prevent or control disease, injury or disability.
* To report births and deaths.
* To report child abuse or neglect.
* To report reactions to medications, problems with products or other adverse events.
* To notify people of recalls of products they may be using.
* To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

* To avert a serious threat to you or others. These disclosures would be made only to someone able to intervene.
* To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence.
* Immunization records to a school requiring such for entry, provided informal approval is given by a parent, guardian, or the patient if the patient is an adult or emancipated minor.
* To Disaster Relief agencies (such as the Red Cross) for notification as to your location and condition.
* If you are an organ donor, we may release health information to the organizations that handle the process, as necessary to facilitate the donation.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs if you have a work related injury.

Health Oversight Activities: Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. may disclose health information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may be required to disclose your health information in response to a court order, administrative order, subpoena, discovery request or other lawful process by someone involved in the dispute.

Law Enforcement: We may disclose health information to law enforcement officials for reasons such as:
* In response to a court order, subpoena, warrant, summons or similar process.
* To identify or locate a suspect, fugitive, material witness or missing person.
* About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
* About a death we believe may be the result of criminal conduct.
* About criminal conduct at our facility.
* In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Health Records of Deceased Patients: We may disclose health information to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral home directors as necessary to carry out their duties. We may disclose to relatives or close personal friends who were involved with the patient's care prior to death, health information relevant to their involvement. HIPAA privacy protections continue until 50 years after the patient's death.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Legal Requirements: We will disclose health information about you without your permission when required to do so by federal, state or local law.

Other Uses and Disclosures Require Your Authorization

Other uses and disclosures of health information not covered by this notice or applicable laws will be made only with your written permission (called "authorization"). If you do give authorization in some instances, you may revoke that authorization in writing at any time. Uses and disclosures of your personal information that require your authorization include marketing functions, and most disclosures that involve sale of health information. Your authorization is also required before we can use or disclose psychotherapy notes about you for any purpose other than basic treatment and healthcare operations.

Your Health Information Rights

You have the following rights concerning your health information:

1. Request a restriction on certain uses and disclosures of your information. We may agree to your request but are not required by law to do so, with the one following exception (item 2)...

2. Restricting disclosures to health plan or insurance for treatment you pay for in full. (The one exception to item 1 above) If you pay in full at the time of service and request we not disclose the information to your health plan or insurer, we must and will comply.

3. Obtain a copy of this Notice of Privacy Practices upon request.

4. Inspect and/or request a copy of your health record. You must make the request in writing, and we have 30 days to comply.

5. Request an amendment to your health record if you feel the information is incorrect or incomplete. Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc. may deny your request if, for instance, we believe it is accurate and complete as it stands.

6. Obtain an accounting of disclosures of your health information. This will include the times when someone used or disclosed your health information other than the allowed common uses and disclosures, or uses and disclosures that you authorized.

7. Request communication of your health information by alternative means or locations. For instance: an address or phone number other than your home.

8. Revoke a previously agreed upon authorization except to the extent that action has already been taken.

For more information contact our privacy officer: Vanessa Chaplin, Disc and Spine, 1320 El Capitan Drive, Suite 200, Danville CA 94526, Phone: (925)275-0700, Fax: (925)275-0701, Email: appointments@discandspine.com.

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A copy of the current notice in effect will be available at Disc and Spine partnership of Robert A. Rovner MD A Prof. Corp., and Vikram Talwar MD Inc.

Effective Date: 8/18/2018

Acknowledgment of Receipt

Disc and Spine a partnership of

Robert A. Rovner MD, A Professional Corporation and Vikram Talwar MD Incorporated

NOTICE OF PRIVACY PRACTICES

By signing this page you acknowledge that you have received a copy of our Notice of Privacy Practices.

Print Name of Patient _____

Signature of Patient _____
(or Personal Representative)

Print Name of Personal Representative _____
(if NOT Patient)

Date Signed _____

Witnessed by _____

Effective Date: 8/18/2018

ROBERT ROVNER, MD, A PROFESSIONAL CORPORATION

FINANCIAL POLICIES

Full Name:_____Date of Birth:_____

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 There is a $**25.00** fee for the completion of all forms up to 3 pages and **$10.00** for each additional page 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.

Radiology Image Copies For X-Rays taken at Disc and Spine, the first CD is complementary, there will be a **$10.00** fee for any additional CDs. There will be a **$15.00** fee for all CD copies of images taken at outside facilities i.e. MRIs, CTs.

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 (DME) During your visit, DME 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.

_____ _____

Patient/ Guarantor Signature **(Date)**

ROBERT A. ROVNER, MD

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Fellow American Board of Orthopedic Surgery

American Academy of Orthopedic Surgery

Pursuant to Assembly Bill (AB) 1278, Robert A. Rovner, MD is required to provide a notice to their patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

California law requires that Robert A. Rovner, MD disclose to you organizations in which Robert A. Rovner, MD or a member of his immediate family may have a financial interest. A financial interest includes but is not limited to any type of ownership, interest, debt, loan, lease arrangement, compensation, remuneration, discount, rebate, refund, dividend, distribution, or have served as a paid consultant. Occasionally, Robert A. Rovner, MD may refer you to such an organization.

This notice is to inform you that Robert A. Rovner, MD may have a financial interest or may have been paid as a consultant in the following entities:

Disc and Spine; Executive Surgery Center; East Bay Special Imaging; Synthes Spine; Omni Medical; Spine 360; Allez Spine (aka Phygen); Scientx Spine; Quantum Spine; Fremont Surgery Center; Crosslink Medical LLC, Aardvark Medical Sales; BRP Pharmaceuticals, Centinel Spine; Precision Spine; Global Financial Services; Innovasis; Doctors MOB LLC, all offices at 1320 El Capitan Danville Ca. 94526; RovnerTalwar LLC, Ortho McNeil, Globus, Trius, Amendia, and Vertebron, Alphatec

Under California law, you may receive equipment, implants, medications, and/or services for which Robert A. Rovner, MD is referring you to from any organization of your choice.

Thank you,

Robert A. Rovner, MD

Patient/ Guardian Signature:_____ Date:_____

Patient Name:_____

Updated 1/2024

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

Preferred Pharmacy

Effective January 1, 2022 all prescriptions must be electronically prescribed. In an effort to facilitate this process please provide the information of your preferred pharmacy to be kept on file should a prescription be issued.

Patient Name:_____ DOB:_____

Pharmacy Name: _____

Pharmacy Street Address: _____

Pharmacy City:_____

Pharmacy Zip Code:_____

Pharmacy Phone Number:_____

Patient Signature:_____ Date:_____