PATIENT REGISTRATION

PATIENT INFORMATION

NAME (Last, First, Middle)		SS #	DATE OF BIRTH	SEX ☐ M ☐ F
LOCAL ADDRESS	APT/UNIT	CITY, STATE, ZIP		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED	RACE	ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC NOR LATINO ☐ REFUSED TO REPORT		
EMPLOYMENT STATUS	STUDENT STATUS	WHO REFERRED YOU? ☐ FAMILY OR FRIEND ☐ WEB/INTERNET SITE ☐ OTHER:		
EMPLOYER		PHONE #		
EMPLOYER ADDRESS		CITY, STATE, ZIP		
PRIMARY CARE PHYSICIAN	PHONE #	REFERRING PHYSICIAN	PHONE #	

GUARANTOR / RESPONSIBLE PARTY

☐ PATIENT ☐ OTHER: RELATIONSHIP:	GUARANTOR / RESPONSIBLE PARTY EMPLOYER
GUARANTOR / RESPONSIBLE PARTY NAME	GUARANTOR / RESPONSIBLE PARTY PHONE ☐ HOME ☐ CELL
GUARANTOR / RESPONSIBLE PARTY ADDRESS	GUARANTOR / RESPONSIBLE PARTY SS #
GUARANTOR / RESPONSIBLE PARTY CITY, STATE, ZIP	GUARANTOR / RESPONSIBLE PARTY DATE OF BIRTH

PRIMARY INSURANCE INFORMATION

NAME OF INSURED PARTY (MAIN SUBSCRIBER)			RELATIONSHIP TO PATIENT
ADDRESS OF INSURED PARTY	APT/UNIT	CITY, STATE, ZIP	
DATE OF BIRTH OF INSURED PARTY	SS # OF INSURED PARTY		PHONE # OF INSURED PARTY
NAME OF INSURANCE			POLICY #
ADDRESS OF INSURANCE COMPANY			GROUP # / GROUP NAME
CITY, STATE, ZIP			PHONE #

SECONDARY INSURANCE INFORMATION

NAME OF INSURED PARTY (MAIN SUBSCRIBER)			RELATIONSHIP TO PATIENT
ADDRESS OF INSURED PARTY	APT/UNIT	CITY, STATE, ZIP	
DATE OF BIRTH OF INSURED PARTY	SS # OF INSURED PARTY		PHONE # OF INSURED PARTY
NAME OF INSURANCE			POLICY#
ADDRESS OF INSURANCE COMPANY			GROUP # / GROUP NAME
CITY, STATE, ZIP			PHONE #

(TURN OVER PLEASE)

PATIENT NAME _____ **DATE OF BIRTH** _____

INJURY DATA INFORMATION	
DATE OF INJURY OR ONSET OF SYMPTOMS	WHERE DID YOUR INJURY OCCUR? ☐ WORK ☐ AUTO ☐ HOME ☐ SCHOOL ☐ OTHER:
CLAIM / CASE MANAGER	CLAIM / CASE #

EMERGENCY CONTACT	
NAME	PHONE #
RELATIONSHIP TO PATIENT	ALTERNATE PHONE #

PRESCRIPTION HISTORY CONSENT

I, _____ authorize Restore Orthopedics and Spine Center to retrieve my prescription history through an external source.

_____ _____

SIGNATURE OF PATIENT/ GUARANTOR / GUARDIAN DATE

I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Restore Orthopedics and Spine Center. I authorize release of information to my insurance carrier should it be necessary. I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Restore Orthopedics and Spine Center. Photo ID and insurance cards must be presented at time of service. Should Photo ID and insurance cards not be presented I will become a cash patient with payment in full at time of service. I further authorize the release of all information necessary to secure payment. I agree to pay any costs incurred by Restore Orthopedics and Spine Center in the collection of amounts due including, but not limited to, reasonable attorney's fees. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

_____ _____

SIGNATURE OF PATIENT/ GUARANTOR / GUARDIAN DATE

PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate full with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicines will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use _____ Pharmacy, located at _____, Telephone number _____ , for filling prescriptions for all of my pain medicines.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this safe's Board or Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or privacy or confidentiality with respect to these authorizations.

PAIN MANAGEMENT AGREEMENT

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____

Patient signature: _____

Physician signature: _____

Spine and Sports Specialties Medical Group

1120 West La Veta Avenue, Suite 300, Orange CA 92868

Privacy Officer: Corinne Walker, Director of Operations, (714) 598-1745

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to Spine and Sports Specialties Medical Group (The Group) to use and disclose protected health information (PHI) about me to carry our treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Group.

_____ With this consent, The Group **may call** my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist The Group in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

Alternative Location: _____

Voice mail number: _____

_____ With this consent, The Group **may mail** my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

Alternative mailing address: _____

_____

_____ With this consent, The Group **may email** me any items that assist The Group in carrying out TPO. Such as appointment reminders, patient statements, and or related communications (by example: Did your phone number change?)

Your email address: _____

Alternative email address: _____

I understand that I have the right to request that the Group restricts how it uses or discloses my PHI to carry out TPO. The Group is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow The Group to use and disclose my PHI to carry out TPO.

(Sign on reverse)

Printed name

Signature

Date