Orthopaedic Associates of Riverside

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Section I - Patient Information

Last Name:_____ First Name:_____ MI_____

Address:_____ __ City:_____ __State_____

Zip Code:_____ Date of Birth _____ ___ Age:_____ M_____ F_____

Marital Status: Single_____ Married_____ Social Security #:_____

Preferred Language:_____ Race:_____ Ethnicity:_____

Home Phone_____ Work Phone_____ Cell phone_____

E-Mail Address_____

Preferred method of contact (please circle): Telephone Text E-Mail

Employer Name_____

Employer Address_____City_____ State_____ Zip Code_____

Is the injury work related? Yes_____ No_____ Is the injury as a result of an accident? Yes_____ No_____

Primary Care Physician_____

Address_____ City_____ Zip code_____

Phone #_____

Section II (Complete if patient is a minor or if insurance holder is different from the patient)

Name of insured_____ Date of birth_____

Social Security#_____ Insurance Co_____

ID#_____ Group#_____

Employer_____ Employer phone_____

Employer Address_____ _____City_____ State_____

Zip Code_____ Phone_____

What is the patient's relationship to you? Spouse_____ Child_____ Other_____

(If Other please define)_____

Staff Initials _____

Section III (Complete if work related injury)

Work Comp Insurance Carrier Name_____

Address_____ **City**_____ **State**_____

Zip Code_____ **Phone**_____ ___**Date of Injury**_____

Supervisor's Name_____ **Phone**_____

Claim #_____

Briefly describe the type of injury & how it occurred:_____

_____

_____

Section IV (Complete if result of an accident)

Where did the accident occur?_____

Name of building, site, etc_____

Address where accident happened_____

Did you report the accident to someone? Yes_____ **No**_____

If yes, name of person you reported the accident to_____

Contact phone number for the person you reported the accident to_____

How did the accident happen? _____

_____

_____

Consent for Treatment

I hereby authorize Orthopaedic Associates of Riverside, its physicians and medical personnel (under physician direction), to conduct such examinations, administer treatment and medications, as they deem necessary and advisable.

_____ **Date**_____
Signature of patient (or guardian)

Acceptance of Financial Responsibility

Orthopaedic Associates of Riverside will, as a convenience to its patients, bill insurance companies for services rendered. However, payment for services rendered is the sole responsibility of the patient and/or his or her guardian. Failure of an insurance company to remit payment does not relinquish the patient and/or his or her guardian from financial responsibility.

_____ **Date**_____
Signature of patient (or guardian)

Staff Initials _____

Authorization to Acquire Medication History

I hereby authorize Orthopaedic Associates of Riverside, its physicians and medical personnel (under physician direction) to acquire my medication history via electronic health records.

_____ Date_____
Signature of patient (or guardian)

Completion of Forms

Due to the overwhelming requests for our medical providers to complete paperwork and in an effort to be fair to all of our patients, we have the following policy in place:

1) Any/all requests for completion of forms will require a pre-payment of $20.00 per form. There are no exceptions to this policy.
2) All forms must be presented at the time of service with payment to the front desk staff prior to your seeing the medical provider.
3) We will not guarantee completion of forms at the time of service. If time permits our providers may be able to complete forms for you at the time of service but realistically it will likely take up to one week to complete.
4) **DO NOT** give forms directly to the medical providers for completion.
5) In the case of upcoming surgeries, our providers can, for no charge, provide you with a written doctors note indicating the date of the surgery and the expected off work time and/or light duty time. However, if your company is requiring a specific form to be completed there will be a charge for this form.
6) In the case of workers compensation cases, our providers will, at each visit complete (for no charge) a work status/activity status form for you to present to your employer, work comp carrier and/or nurse case manager. However, any additional forms for disability or the like will require a $20.00 payment for completion.

Should you have any questions regarding this policy please ask to speak to the front desk supervisor.

_____ _____
Patient or responsible party signature Date

Pharmacy: _____

Pharmacy Address:_____

City_____ Zip code_____

Pharmacy Phone Number: _____

Emergency Contact_____ Phone _____

Relation to Patient:_____

Staff Initials _____