

**Orthopaedic Associates of Riverside**

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**Patient Information**

**Section I**

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

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Is injury work related? Yes \_\_\_\_\_ No \_\_\_\_\_

(If yes, please complete section III)

Is the injury as a result of an accident?  
(If yes, please complete section IV) 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 \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

What is the patient's relationship to you? Spouse \_\_\_\_\_ Child \_\_\_\_\_

Other \_\_\_\_\_ (Please define) \_\_\_\_\_

**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 explain type of injury and 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.

\_\_\_\_\_  
Signature of patient (or guardian) Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

### 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)

### 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