PATIENT'S CONFIDENTIAL FILE

Patient Information Form

(Please Print Clearly)

Patient's Name_______________________________ Sex: M F Social Security #______-______-__________
Last First MI

Home Address_______________________________ City_______________ State______ Zip Code __________

Mailing Address (if different)_______________________ City _______________ State______ Zip Code __________

Home Phone Number# (______) _______________________ Date of Birth____/_____/_____ Age_________

Cell Phone Number (______) _______________________ E-mail Address_______________________________

Referring Physician_____________________________ Marital Status: M | S | W | D

Primary Care Physician_____________________________ Phone Number (_____)____________________

Patient's Employer________________________________ Occupation____________________________

Address _________________________________ City _______________ State _________ Zip_________

Phone (_______)____________________

Emergency Contact ________________________ (_____)____________________ ______________________
(Other than spouse) Name Daytime Phone Relationship to Patient

---

If Patient is a Minor: This Section to be Completed by Person Responsible for Account

Name ______________________________ DOB _____/_____/_________ Social Security #_____-____-_______
Last First MI

Address ______________________________ City ______________ State _________ Zip Code______________

Home Phone ____________________ Cell Phone _____________________ Work Phone ___________________

Employer ____ City ____________ State ______ Zip _________
Name and Street Address

INSURANCE INFORMATION

Is this a Worker's Compensation Claim? (Circle One) Yes | No

If <u>YES</u>, indicate______________________________ ____
Claim Number Adjuster Name and Telephone #

If <u>NO</u>, please complete the following:

Primary Insurance ______________________________ Secondary Insurance ___________________________

Policy Holder's Name ___________________________ Policy Holder's Name___________________________

Policy Holders' Date of Birth ______/________/_________ Policy Holder's Date of Birth _____/_______/__________

Policy Holder Retired? Yes | No Policy Holder Retired? Yes | No

Policy/Subscriber I.D.# ___________________________ Policy/Subscriber I.D.#___________________________

Group Name and/or # ____________________________ Group Name and/or #____________________________

Insurance Address ______________________________ Insurance Address ______________________________

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled; including Medicare and other government sponsored programs, private insurance and any other health plan to ***ROSEVILLE SURGICAL ALLIANCE, INC***. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges that are not covered by said insurance. I hereby authorize said assignee to release all information necessary to secure payment for services rendered.

Signed_______________________________ _______________________________ ______/______/________
(Patient; Legal Guardian if patient is a minor) Print Name Date

Roseville Surgical Alliance, Inc.
5 Medical Plaza, Suite 120
Roseville, CA 95661
(916) 781.2500

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Roseville Surgical Alliance, Inc., and staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Roseville Surgical Alliance, Inc., Notice of Privacy Practices' for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Roseville Surgical Alliance, Inc. reserves the right to revise the office's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

ROSEVILLE SURGICAL ALLIANCE, INC.
ATTN: PRIVACY OFFICER
5 Medical Plaza, Suite 120
Roseville, CA 95661

With my consent, Roseville Surgical Alliance, Inc., and staff may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical are, including laboratory results among others.

With my consent, Roseville Surgical Alliance, Inc., and staff may mail to my home or other designated location any times that assist the practice in carrying out TPO, such as lab, x-ray, or appointment reminder postcards and patient statements. I have the right to request that Roseville Surgical Alliance, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice 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 Roseville Surgical Alliance, Inc., and staff use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Roseville Surgical Alliance, Inc., and staff may decline to provide treatment to me.

_______________________________ _______________________________
Signature of Patient or Legal Guardian Print Name of Legal Guardian

_______________________________ _______________________________
Print Name of Patient Date

ROSEVILLE SURGICAL ALLIANCE, INC.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1006 (HIPPA), in order for your physician or staff member of this practice to discuss your condition with a member of your family or other individual that you designate, we must obtain your authorization prior to doing so. In the event of an emergency or you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may bChart Form RSA Patient Consent of PHI.doce waived.

(Check One)

______***I do not authorize*** Roseville Surgical Alliance, to release any or all information concerning my medical care to any individual except during an emergency as set forth above.

______***I authorize*** Roseville Surgical Alliance, Inc. to verbally, or in written form, release any or all information concerning my medical care to the following individuals.

______***I do*** ______ ***I do not*** authorize Roseville Surgical Alliance, Inc. to verbally or in written form, release any or all information concerning my medical care to my primary care physician (if he/she is not the referring physician).

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

This authorization will remain in effect until revoked by me in writing.

Patient Signature   Print Name   Date

NAME:________________________________ **AGE**:________ **DATE:**____________________

REFERRING PHYSICIAN____

PRIMARY CARE PHYSICIAN ____

REASON FOR THIS VISIT ____

____

LIST ALL MEDICAL CONDITIONS FOR WHCH YOU ARE CURRENTLY BEING TREATED:

____

____

____

____

____

____

____

____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____

LIST ANY MEDICATION ALLERGIES:

____

____

____

____

NAME: ____**AGE**: _______________

LIST ANY PREVIOUS SURGERY AND APPROXIMATE DATE (IF KNOWN):

____

____

____

____

____

____

____

____

____

FAMILY HISTORY:

CANCER: ____

DIABETES: ____

HEART PROBLEMS: ____

BLEEDING PROBLEMS: ____

RESPIRATORY PROBLEMS: ____

PROBLEMS WITH ANESTHESIA: ____

DO YOU SMOKE? Yes | No IF YES, HOW OFTEN? __________________________

DO YOU DRINK ALCOHOL? Yes | No IF YES, HOW OFTEN? ____________________

FEMALE PATIENTS:

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _________

LIVE DELIVERIES? ________________ LAST MENSTRUAL PERIOD: _____________________

THANK YOU!

Nurse will complete remainder of form

DATE_______________ TEMP________ BP__________ P___________ WT#_________