11/10/2021

ALPINE
Orthopaedic Medical Group, Inc.

PETER B. SALAMON, M.D.
EDWARD L. CAHILL, M.D.
ROLAND H. WINTER, M.D.
ANH X. LE, M.D.
ALAN T. KAWAGUCHI, M.D.
GARY M. ALEGRE, M.D.
ALEX H. PHAN, M.D.
MATTHEW J. TAKEUCHI, D.P.M.
JAICHARAN J. IYENGAR, M.D.
MICHAEL Y. LIN, M.D.
JASPREET S. SIDHU, D.O.
PRATIK J. GANDHI, D.O.
JEFFREY J. MACLEAN, M.D.
JAMES M. FRIEDMAN, M.D.
KYLE M. NATSUHARA, M.D.
CHRISTOPHE T. ANSLINGER, PA-C

Your appointment is scheduled with:

at

We respect your time and would like to make your visit to our office as efficient and productive as possible. Below is a list of items that you will need to bring into the office at the time of your appointment. It is your responsibility to make sure the requested information is here for your appointment.

1. The enclosed forms must be fully completed.

2. Medical insurance information, including your insurance card, referral and/or authorization, must be presented at the time of your appointment.

3. All co-payments are due at the time of service. We do accept VISA and MasterCard.

4. You **Must** present a picture I.D.

5. Please make arrangements for your x-rays **(CD & report)**, both scans **(CD & report)**, MRI scans **(CD & report)**, etc., to be with you at the time of the exam. **A CD copy is preferred** but films are acceptable.

6. Please bring a list of your current medications including dosage.

7. Please make provisions for an interpreter if needed.

If this information is not available at the time of your scheduled appointment, it may not be possible for the physicians to provide you with a complete evaluation. In such cases our physicians may choose to reschedule your appointment to a time when all necessary information becomes available.

Please call the office at **(209) 948-3333** with any questions you may have. Thank you.

Our office is located at: **2488 N. California Street, Stockton, Ca 95204**

*Team Physicians for the University of the **Pacific Tigers** and the **Stockton Ports***

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VANESSA FERRARIO, PA-C

Acct_FullName

DISCLOSURE STATEMENT

Please sign this statement in the presence of a witness and bring the signed paper with you to your appointment.

In compliance with California State Law found in business and professional code **section 654.2 and labor code 139.3**, this notice is to inform you that your surgeon has an ownership interest in one or more of the following entities that supply MRI scans and/or outpatient surgical services to the hospital to which you have been referred and such goods and services may be ordered for your surgery. You are free however to obtain orthopaedic instrumentation or hospital services for any products of your choosing:

*Ambulatory Surgery Center of Stockton
*Alpine Orthopaedic MRI (On site MRI facility)

I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing.

SIGNED: _____ DATE: _____

WITNESS: _____ RELATIONSHIP: _____

INTERPRETER: _____ DATE: _____
(if applicable)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
ANNE MCCUNE PRIVACY OFFICER (209) 948-3333

I hereby acknowledge that I was advised of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices.

_____ I **declined** a written copy of any Notice of Privacy Practices provided by Alpine Orthopaedic Medical Group

_____ I **received** a written copy of any Notice of Privacy Practices provided by Alpine Orthopaedic Medical Group

SIGNED: _____ DATE: _____

PRINT NAME: _____ TELEPHONE: _____

If not signed by patient, please indicate: _____ Parent or guardian of minor patient
_____ Guardian or conservator of incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of patient: _____

ALPINE ORTHOPAEDIC MEDICAL GROUP, INC.

DOCTOR _____ DATE _____ ACCT CAT: _____ ACCT# _____

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION. EACH LINE SHOULD BE ANSWERED, IF UNKNOWN OR NOT APPLICABLE, PLEASE INDICATE (N/A)

HEIGHT _____

PATIENT'S NAME _____ WEIGHT _____
LAST FIRST MIDDLE

ADDRESS _____ BIRTHDATE _____
NUMBER AND STREET CITY, STATE, ZIP

MAILING ADDRESS (*if different)* _____ AGE _____ SEX _____

PHONE # _____ DRIVER'S LIC. # _____ SOC. SEC. # _____

CELL # _____ PATIENT'S E-MAIL _____

CURRENT EMPLOYER/SCHOOL _____ STUDENT FULL/PART TIME
NAME NUMBER AND STREET CITY, STATE, ZIP

EMPLOYER PHONE # _____ OCCUPATION _____

PARENT/SPOUSE OR RESPONSIBLE PARTY:

NAME _____ RELATIONSHIP _____
LAST FIRST MIDDLE

ADDRESS _____ BIRTHDATE _____
NUMBER AND STREET CITY, STATE, ZIP

PHONE # _____ CELL # _____ SOC. SEC. # _____

EMPLOYER _____ DRIVERS LIC # _____

EMPLOYER ADDRESS _____
NUMBER AND STREET CITY STATE ZIP

EMPLOYER PHONE # _____ OCCUPATION _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY _____ PHONE # _____
NAME RELATIONSHIP

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE # _____

DATE OF INJURY OR ONSET OF ILLNESS? _____ INJURY? (YES NO) Work Auto Other _____

HOW INJURED _____ PART OF BODY _____ LT - RT

ON THE JOB INJURY? YES NO EMPLOYER NOTIFIED? YES NO EMPLOYER AT TIME OF INJURY _____

WORKMAN'S COMP./THIRD PARTY _____

ADDRESS _____ PHONE # _____

CLAIMS ADJUSTER _____ CLAIM # _____ PHONE # _____

☐ CONSULT ONLY ☐ EVAL & TX

WHICH PHARMACY DO YOU USE?

NAME _____

STREET _____

CITY _____ PHONE _____
(IF KNOWN)

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I CERTIFY THE ABOVE ANSWERED INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____
(INSURED OR AUTHORIZED PERSON)

HPI

Doctor: _____

Name: _____ Date: _____ Acc#: _____ New Patient or New Problem

Occupation: _____ DOB:

Onset: When did problem begin or injury happen? _____ **PLEASE COMPLETE BOTH FORMS** →

What are your goals for today's visit?

Please circle the numbers below that most apply to you:
I can still accomplish most of my goals in life, despite the pain/circumstance:
Not at all confident **0 1 2 3 4 5 6** *Completely confident*
I can live a normal lifestyle, despite the pain/circumstance:
Not at all confident **0 1 2 3 4 5 6** *Completely confident*

PCP or Referring Doctor: _____ Height _____ Weight _____

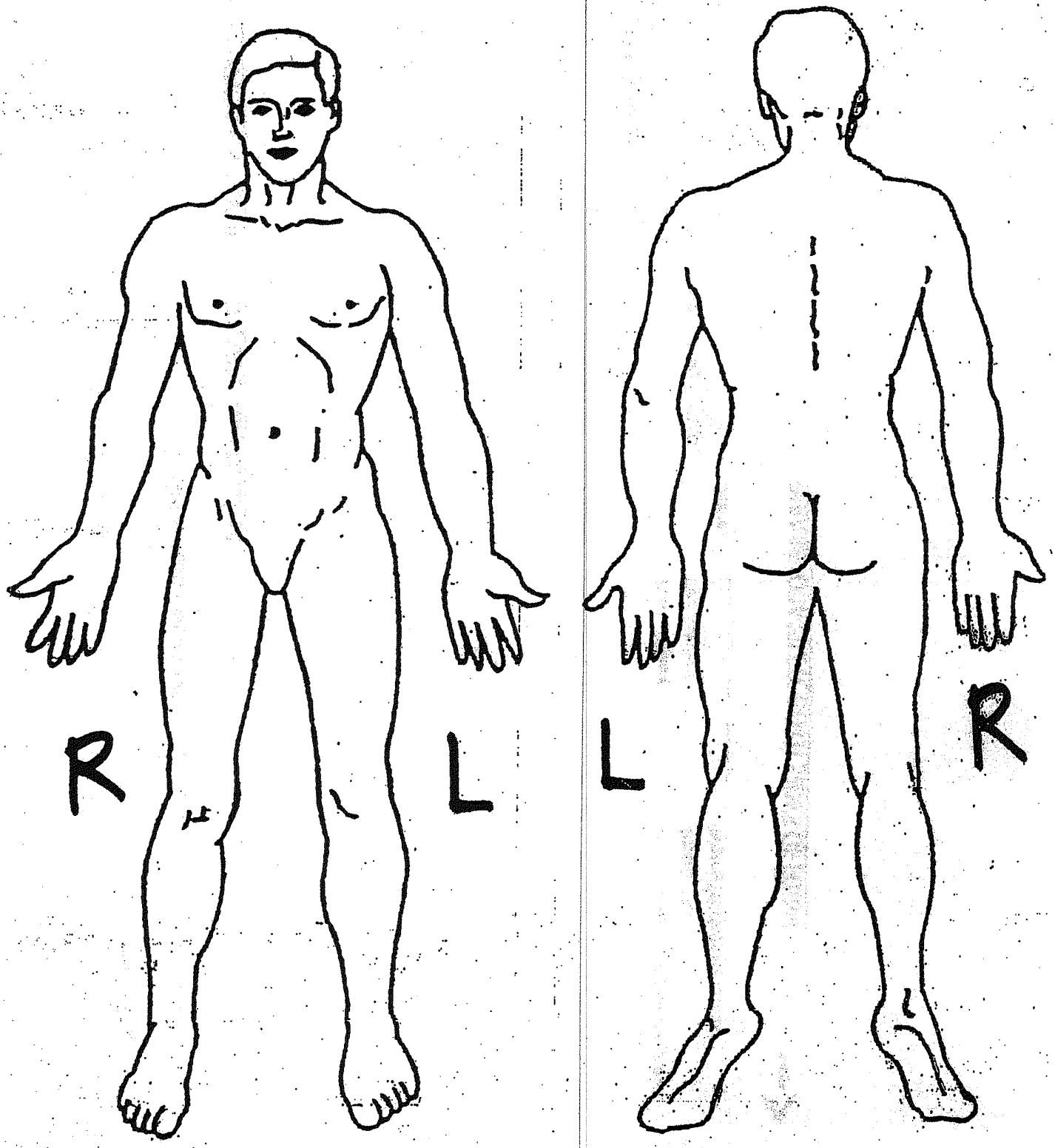
Have you had any treatment?:	**Xrays**	**NCV/EMG/Nerve Conduction**	**MRI/CT/Bone Scan**	**Physical Therapy**
Medication Tried:	Yes / No When: Where:	Yes / No When: Where:	Yes / No When: Where:	Yes / No When: Where:
	Injections	**Splinting or Bracing**		
Please circle applicable statements:	Yes / No	Yes / No If so, what type:		

Condition:		**Injured where or how:**	**Injured as a result of:**	**Sensation:**	**Limitations:**
Bruising or Ecchymosis	Mass				
Catching	Spasm	Athletics	Bending	Feels unstable	Cannot bear weight
Clicking or triggering	Numbness	Home	Direct blow	Felt a grinding	Cannot extend
Deformity	Pain	Motor vehicle accident	Fall	Felt a pop	Cannot flex
Giving Way	Redness	Retail business	Hyperextension	Felt a sharp pain	Cannot move
Instability	Stiffness	School	Lifting weight	Felt a snap	Was able to continue
Locking	Swelling	School athletics	Reaching	Heard a pop	Was carried off
Loose Body	Tingling	Work	Sudden change in direction		
Loss of motion	Weakness				

Swelling	**Condition Aggravated by:**		**Condition Relieved by:**	
	Bending	Running	Activity	Anti-inflammatory medication
Did not swell	Daily activities	Sit to Stand	Compression wrap	Pain medication
Swelled immediately	Exercise	Sitting	Elevations	Physical Therapy
Swelled the next day	First Step	Sports	Heat	Rest
Swelled within a few hours	Going down stairs	Squatting	Ice	Tylenol
	Going up stairs	Walking	Injections	
	Kneeling	Work activities	No relief	
	Motion			

Mark areas on your body where you feel the described sensations using the appropriate symbols from the list below:

Pain	Numbness	Pins & Needles
xxxx	- - - -	oooo
xxxx	- - - -	oooo



Name _____ Date _____

ALPINE ORTHOPAEDIC MEDICAL GROUP, INC.

2488 N. California Street * Stockton, CA 95204-5508 * Telephone (209) 948-3333

PATIENT NAME: DATE: _____

PREFERRED LANGUAGE:

ENGLISH:_____ SPANISH:_____ OTHER:_____

Do you require language interpretation assistance? Yes or No

Please list the medications you are currently taking:

☐ I am not taking any prescribed medications.

Medication Name	**Dose**	**Times Per Day**

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PATIENT NAME: DATE: _____

Alpine Orthopaedic Medical Group, Inc., is required by federal regulations to request the following demographic information: ethnicity, race, preferred language and email address:

ETHNICITY: (PICK ONE ONLY)

- ☐ African
- ☐ Asian
- ☐ Cuban
- ☐ Hispanic or Latino
- ☐ Irish
- ☐ Italian
- ☐ Jewish
- ☐ Native American
- ☐ Not Hispanic or Latino
- ☐ Polish
- ☐ None of the above
- ☐ Unreported/Refused to give ethnicity

RACE: (PICK ONE ONLY)

- ☐ Multiracial
- ☐ American Indian
- ☐ Asian Indian
- ☐ Black
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hispanic
- ☐ Japanese
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ None of the above
- ☐ Unreported/Refused to give race

PREFERRED LANGUAGE:

ENGLISH:_____ SPANISH:_____
OTHER:_____

EMAIL ADDRESS: _____

*PLEASE USE A SLASH THROUGH YOUR 0 FOR THE NUMBER ZERO