PATIENT INFORMATION FORM

PATIENT INFORMATION				
Patient Name	Last	First	Date of Birth	Age
Street Address			❑ Male ❑ Female	
City	State	Zip Code	Social Security Number	
Home Phone	Work Phone	Cell Phone	E-Mail	
Employer Name	**Occupation**	**Employment Status** ❑ Full ❑ Part ❑ Ret	**Work Injury?** ❑ Yes ❑ No	**Auto Related?** ❑ Yes ❑ No

Primary Care Physician

Address of Primary Care Physician — Phone Number of Family Physician

Who Referred You To Our Office?

❑ Family Physician ❑ Other Physician_____ ❑ Friend ❑ Insurance Company ❑ Lawyer ❑ Other_____

Have You Been Seen By Any Physician In This Practice Before?

❑ No ❑ Yes

Emergency Contact Name	**Relationship**	**Home Phone Number**	**Work Phone Number**

HISTORY OF PROBLEM

Please Explain Briefly Why You Are Seeing The Doctor. *(Specify LEFT or RIGHT)*

First Symptom OR Date of Injury.

How Did Injury Occur & Where?

INSURANCE INFORMATION

(Please Present Insurance Cards to Receptionists)

Subscriber Name	
Primary Insurance Company	Secondary Insurance Company
I.D. Number	I.D. Number
Group Number	Group Number

❑ Check here if you believe Worker's Compensation is responsible for payment

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize ROGER A. MANN, MD., INC., JEFFREY A MANN, M.D INC. and/or BASIL J. ALWATTAR, M.D. to release information regarding my treatment or examination rendered to me for medical or surgical care to my insurance company (s) or its representatives. I also authorize payment to be made directly to ROGER A. MANN, M.D., INC, JEFFREY A MANN, M.D INC. and/or BASIL J. ALWATTAR M.D. in the amount due for all medical and/or surgical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company (s). Furthermore, I authorize ROGER A. MANN, M.D., INC. , JEFFREY A. MANN, M.D and/or BASIL J. ALWATTAR M.D.., to obtain my medical records from any necessary hospital, clinic, or doctor's office.

SIGNATURE X DATE

PATIENT HEALTH QUESTIONNAIRE

PAST MEDICAL HISTORY: Please list all past medical history including any medications and current status

High Blood Pressure	❑**Yes**	❑**No**	Medication and Status: _____
Diabetes	❑**Yes**	❑**No**	Medication and Status: _____
Osteoarthritis	❑**Yes**	❑**No**	Medication and Status: _____
Heart Disease	❑**Yes**	❑**No**	Medication and Status: _____
Osteoporosis	❑**Yes**	❑**No**	Medication and Status: _____
Depression	❑**Yes**	❑**No**	Medication and Status: _____
High Cholesterol	❑**Yes**	❑**No**	Medication and Status: _____
Thyroid	❑**Yes**	❑**No**	Medication and Status: _____
Other:			

MEDICATIONS: Please indicate all medications you take regularly.

Check bottle label for the dose and frequency that you take the medications. Please attach additional sheets if necessary.

Name:	Strength:	Frequency:	Last Time Taken:	Name:	Strength:	Frequency:	Last Time Taken:
Example: Pepcid	**20mg**	**1 pill 2 times a day**	**01/15/13**	**5)**			
1)				**6)**			
2)				**7)**			
3)				**8)**			
4)				**9)**			

ALLERGIES AND SENSITIVITIES: Please indicate any allergies you are aware of in the space below.

Penicillin or other antibiotics	❑**Yes**	❑**No**	❑**Unsure**	Reaction:
Morphine, Codeine, Demerol, or other narcotics	❑**Yes**	❑**No**	❑**Unsure**	Reaction:
Aspirin or other pain medication	❑**Yes**	❑**No**	❑**Unsure**	Reaction:
Sulfur Drugs	❑**Yes**	❑**No**	❑**Unsure**	Reaction:
Tetanus Antitoxin or other serums	❑**Yes**	❑**No**	❑**Unsure**	Reaction:
Adhesive tape or surgical tape	❑**Yes**	❑**No**	❑**Unsure**	Reaction:
Any foods (i.e. eggs, milk, chocolate, etc.)	❑**Yes**	❑**No**	❑**Unsure**	Reaction:
Other (Please list):				

PAST SURGICAL HISTORY: Please list all past surgical procedures. Attach additional sheets if necessary.

Procedure:	Date:	Surgeon:

PERSONAL HEALTH: Please answer Yes or No to all questions below.

1. Heart condition	❑ **Yes**	❑ **No**	7. Arthritis, Gout, Rheumatism	❑ **Yes**	❑ **No**
2. Stomach Ulcers	❑ **Yes**	❑ **No**	8. Painful or swollen joints	❑ **Yes**	❑ **No**
3. Blood/Clotting Disorder	❑ **Yes**	❑ **No**	9. Muscle weakness or atrophy	❑ **Yes**	❑ **No**
4. Kidney Disorder	❑ **Yes**	❑ **No**	10. Skin Conditions	❑ **Yes**	❑ **No**
5. Stroke	❑ **Yes**	❑ **No**	11. Asthma/COPD	❑ **Yes**	❑ **No**
6. Fractures, Sprains or Dislocations	❑ **Yes**	❑ **No**	12. Are you pregnant?	❑ **Yes**	❑ **No**

FAMILY HISTORY: Do you have a family history of the any of the following conditions, list the family members affected.

Cancer	❑**Yes**	❑**No**	Family Member:
Diabetes	❑**Yes**	❑**No**	Family Member:
Osteoarthritis	❑**Yes**	❑**No**	Family Member:
Heart Disease	❑**Yes**	❑**No**	Family Member:
Other:			Family Member:

SOCIAL HISTORY:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other _____
Height: _____ **Weight:** _____ **Primary Language:** _____ ❑ Decline
Race: _____ ❑ Decline **Ethnicity:** _____ ❑ Decline
Tobacco Use? ❑ Never ❑ Former ❑ Some Days ❑ Every Day ❑ Yes, Unknown Frequency ❑ Frequency _____
Alcohol: Beer, Wine, Liquor ❑ Never ❑ Rarely ❑ Weekly ❑ Daily ❑ Type/Amount _____
Illicit Drug Use: ❑ Yes ❑ No Type: _____
Hobbies & Activities: _____
_____

Oakland Bone & Joint Specialists

◆ORTHOPAEDIC SPECIALISTS◆

80 Grand Ave., Fifth Floor, Oakland, CA 94612 / (510) 451-6266 FAX (510) 451-6260

Roger A. Mann, M.D., Jeffrey A. Mann, M.D., Basil J. Alwattar, M.D.

Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: _____

***For Office Use Only*:**

- ❑ Signed form received by: _____
- ❑ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

OAKLAND BONE AND JOINT SPECIALISTS
ROGER A. MANN, M.D.
JEFFREY A. MANN, M.D.
BASIL J. ALWATTAR, M.D.
◆**ORTHOPAEDIC SPECIALISTS**◆
80 Grand Ave., Fifth Floor, Oakland, CA 94612 / (510) 451-6266 FAX (510) 451-6260

FINANCIAL POLICIES

We realize medical bills involving health insurance can be very complicated. Our goal is to help you become aware of your responsibilities as an insured member. Our billing department can be reached at (510) 451-6266 ext 208 and the billing supervisor at (303) 470-9595 if you have questions regarding this.

Please bring your insurance card to the office for every visit.
You must bring your insurance card on your first visit, and your new insurance cards if at any time your insurance coverage changes. When you book your initial exam our office staff can confirm that we are or are not contracted providers for major insurance carriers, such as Medicare, Anthem Blue Cross, Blue Shield, Aetna, Health Net and United Healthcare. It is ultimately the patient's responsibility to confirm directly with their insurance that we are contracted providers before being seen. A customer service representative at your insurance can confirm that information for you with the following:

Dr. Roger Mann's tax ID 94-2478647 or Dr. Jeffrey Mann/Dr. Basil Alwattar's tax ID 04-3804329
We strongly recommend that you get a reference or tracking number for all calls to your insurance company.

Your Copay is due at the time of service.
If you do not bring a method of payment for your Copay at the time of your visit, we will add a $20.00 billing fee on top of your Copay amount. Your Copay is due whether you are seeing a physician or their physician's assistant for an office visit.
If you have no insurance, or if we are not able to verify your insurance eligibility, we ask that you pay for the visit at the time of service.
If we do not have verification that you are covered by an insurance plan, you will be expected to pay the charges in full at the time of the visit. If we receive payment from insurance, we will promptly refund any credit on your account.
We do not bill third-party insurance. You will need to cash pay at the time services are rendered.
If you have been injured in an auto accident, you must tell the front office staff when you check in. You will be responsible for payment in full at the time of service.
If your insurance delays payment:
If your insurance carrier does not make payment within 90 days, the balance will be due in full from you. If there is a problem or a dispute over payment with the insurance carrier, this is a matter for you to address with them directly. If payment is made by your insurance carrier in excess of the balance we estimated, we will promptly refund the credit amount to you.
It is our office policy to send out 3 patient billing statements for balances due.
After which we will roll your account over to an outside collection agency. To avoid this action, please contact our billing department and set up a payment plan if necessary. Payment plans that are not honored per verbal agreement are rolled over to our collection agency directly. This is also why it is imperative that: **you update your address, telephone and employer information with us.**
I have read and understand the above noted policies

Patient or Guardian_____**date**_____

Oakland Bone & Joint Specialists

ROGER A. MANN, M.D.
JEFFREY A. MANN, M.D.
BASIL J. ALWATTAR, M.D.

APPOINTMENT DATE AND TIME: _____

THERE WILL BE A $25 NO SHOW FEE FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS

PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

- Your insurance information, Photo ID and Copay
- Any pertinent x-rays, MRI's, etc.
- A Referral (if one is required by your insurance)
- The attached forms

DIRECTIONS TO THE OAKLAND OFFICE:
80 Grand Ave, Fifth Floor Oakland, Ca. 94612
(corner of Grand and Broadway)
(510) 451-6266

When approaching from Orinda, Lafayette & Walnut Creek via the 980 Freeway (Hwy 24 through the Caldecott Tunnel):
Take the 27th Street / West Grand Avenue exit. At the bottom of the ramp, make a left turn onto 27th Street. Follow 27th Street to Broadway & make a right turn onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

When approaching from the East on Interstate 580 (from San Leandro):
Take the Harrison Street / MacArthur Blvd. exit. The ramp becomes MacArthur without making a turn. Follow MacArthur to Broadway & make a left onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

When approaching from the West on Interstate 580 (from San Francisco, Berkeley & the North Bay):
Take the Webster Street / Broadway exit. The exit will offer two choices – take the left hand option of the exit to Broadway South. Make a right turn onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

When approaching from the South on Interstate 880 (from Alameda):
Take the Broadway exit. At the bottom of the ramp, make a right hand turn onto Broadway. Follow Broadway to Grand Ave. The building is located on the corner of Broadway and Grand Ave.

There is a parking lot attached to the building but it is privately owned so there is a fee for Parking.
***Dr. Roger Mann patients please note:** Due the nature of our specialized practice, extended waiting periods may occur. We apologize in advance for any inconvenience. We are trying to provide the best medical care for each individual patient. Thank you for your understanding regarding this concern.