Sacramento Orthopedic Sports & Shoulder
Greg Takenishi, MD
Orthopedic Sports Medicine & Shoulder Arthroplasty

2801 K Street, #330, Sacramento, CA 95816
Phone: (916) 732-3005 Fax: (916) 732-3023
www.sacorthosports.com

DATE	PRIMARY CARE PHYSICIAN (PCP)	REFERRING PHYSICIAN

Patient Information

FIRST / MIDDLE NAME	LAST NAME	SOCIAL SECURITY NO.

DATE OF BIRTH	AGE	SEX	MARITAL STATUS

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

EMAIL ADDRESS

ARE YOU EMPLOYED?	NAME OF EMPLOYER	OCCUPATION

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE	CELL PHONE

Primary Insurance (Copay expected at time of service)

INSURANCE PROVIDER	ID NUMBER	GROUP NUMBER

SUBSCRIBER NAME (FIRST, LAST)	RELATIONSHIP TO PATIENT

DATE OF BIRTH (IF NOT SELF)

Secondary Insurance

INSURANCE PROVIDER	ID NUMBER	GROUP NUMBER

SUBSCRIBER NAME (FIRST, LAST)	RELATIONSHIP TO PATIENT

Person Responsible for Your Account (If self, skip this section)

FIRST NAME	LAST NAME	SOCIAL SECURITY NO.

STREET ADDRESS	CITY	STATE	ZIP

CONTACT PHONE	DATE OF BIRTH	RELATIONSHIP TO PATIENT

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LAST NAME	FIRST / MIDDLE NAME	DATE	HEIGHT (Ft / In)	WEIGHT (Pounds)

Medical & Surgical History

Check all items that pertain to your medical history, whether past or present. Please provide us with an explanation below for any checked item, as well as a doctor's name and phone number if you are currently being treated.

- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Blood Clot
- ☐ Cancer/Leukemia
- ☐ Diabetes
- ☐ Heart Problems/Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Problems/Asthma
- ☐ Neck or Back Problems
- ☐ Neurologic Problems
- ☐ Previous Surgery
- ☐ Stomach & Intestinal Problems
- ☐ Stroke/Seizures
- ☐ Thyroid Problems
- ☐ Anesthesia Problems
- ☐ Psychiatric Problems
- ☐ I may be pregnant
- ☐ I am or was a smoker
- ☐ I used to or currently drink alcohol
- ☐ I use or have used recreational drugs
- ☐ Other

EXPLANATION	DOCTOR NAME / NUMBER (IF APPLICABLE)

Allergies

ARE YOU ALLERGIC TO ANY MEDICATIONS?	ARE YOU ALLERGIC TO LATEX GLOVES?	ARE YOU ALLERGIC TO SURGICAL TAPE?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If yes to any of the above, please provide details below:

ALLERGY	REACTION

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Patient Information

LAST NAME	FIRST NAME	DATE

Medications

Please list any medications you are currently taking (including over-the-counter medications such as Advil, Tylenol, Aleve, Asprin, etc.). Please also list all natural vitamins, supplements, steroids, diet pills and herbs that you take.

MEDICATION	DOSE	FREQUENCY (HOW OFTEN YOU TAKE)

Are You Physically Active?

If yes, please describe the type and frequency of activities. (This may include work-related activities.)

TYPE OF ACTIVITY	FREQUENCY

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LAST NAME	FIRST NAME	DATE

Financial Agreement

Dr. Takenishi's practice specializes in orthopaedic surgery, which involves treating bone, joint, muscle, and ligament disorders. Before we are able to assist you, it is important that you understand you are responsible for the payment of any charges incurred during your visits to this office. For your benefit, we have explained the two scenarios that govern the financial agreement between our office and you, the patient.

A: I have health insurance
If you carry health insurance, the total fee for medical services rendered is still charged to you and not the insurance company (unless otherwise stated); which means that your name, not the insurance company's, will be on the bill as the one responsible for charges. Once we generate a bill, we will submit it on your behalf to your insurance carrier. Depending on your coverage, the insurance carrier will cover all, a portion of, or none of the fees. Any balance due will be your responsibility, and as such, you will receive an invoice from our office.

If a procedure is not covered by your insurance carrier, and you still request to have that procedure performed, we will bill your insurance carrier first as a courtesy. If the claim is denied, you will be responsible for the full amount of the procedure.

Unfortunately, this office cannot accept responsibility for collecting unpaid insurance claims or for negotiating a settlement on a disputed claim. While we facilitate the process, you are ultimately responsible to ensure payment in a timely manner.

B: I wish to pay for services on my own
In some cases, our patients ask to pay directly for services. We are happy to accommodate such arrangements.

Please indicate your payment instructions:

☐ **I would like my final invoice to be submitted to my insurance carrier.**
I hereby authorize my insurance benefits be paid directly to **Dr. Takenishi** by my insurance carrier and authorize the release of any information necessary to process all claims. A copy of this authorization shall be as valid as the original.

☐ **I would like to pay my invoice directly.**
I hereby direct that **Dr. Takenishi** shall not bill my insurance company for services provided to me, and instead, I agree to pay all fees associated with my visits to his office.
Or
I do not have insurance, or insurance **Dr. Takenishi** accepts, and would like to pay out-of-pocket for my visit.

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Please initial each of the items below

Records Release
I hereby authorize Dr. Greg Takenishi and his office staff to release to my referring physician, insurance company, attorney, or legal guardian, any information, including diagnosis and records or treatment, concerning my medical history and orthopaedic care. Any data collected may be used in any publication, providing my real name is not used.

INITIAL HERE

Media Release and Consent
I give Dr. Greg Takenishi all rights, title and interest in the photographs, audio recordings, video recordings, and/or interview/questionnaire answers (collectively or individually "Information") obtained of or from me to be used in any manner, and in any media, in connection with the services rendered by Dr. Takenishi. Your name and any other identifying information will be removed and never used or shown.

INITIAL HERE

Medicare Patient Signature Authorization (for Medicare patients only)
I authorize any holder of medical or other information about me to release my complete records to the Social Security Administration and Health Care Financing Administration — or its intermediaries or carriers, billing agent of Dr. Takenishi, or supplier — needed for this or related Medicare plan.

I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made to Dr. Takenishi on any bills for services provided to me by him during the period from ____________ to December 31, 20____.

INITIAL HERE

Privacy Policy Acknowledgement
I acknowledge I have access to, have reviewed or have received a copy of Dr. Takenishi's Notice of Privacy Practices.

INITIAL HERE

"No Show" Policy
We require a 24-hour notice on cancellations or rescheduled appointments. Failure to do so will result in a $35 charge.
You may be discharged as a patient and sent to your primary care physician for referral to another orthopaedic surgeon if you:

- Cancel or reschedule more than 3 times
- No show or failure to cancel or reschedule appointment prior to 24 hours more than 2 times

INITIAL HERE

I have read and agree to all of the initialed and marked items above.

PATIENT/GUARDIAN SIGNATURE DATE

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LAST NAME	FIRST NAME	DATE

Injury Description

WHICH KNEE IS AFFECTED? ☐ Right ☐ Left	DATE OF INJURY OR ONSET (IF NOT SURE, ESTIMATE):	DID YOU HAVE ANY PREVIOUS PROBLEMS WITH THIS KNEE? ☐ Yes ☐ No
DESCRIBE PROBLEM		
WAS INJURY RELATED TO WORK? ☐ Yes ☐ No	WAS INJURY RELATED TO AN AUTO ACCIDENT? ☐ Yes ☐ No	IS THIS INJURY POTENTIALLY GOING TO BE IN LITIGATION? ☐ Yes ☐ No

Previous Treatment

Have you taken NSAID's for your knee pain? (i.e. motrin, ibuprofen, advil, naprosyn, aleve, celebrex, etc.) ☐ Yes ☐ No

WHICH ONES?	DID THEY HELP THE PAIN? ☐ Yes ☐ No

Have you done physical therapy for this knee? ☐ Yes ☐ No

WHERE?	DID THEY HELP THE PAIN? ☐ Yes ☐ No

Have you had any shots to this knee? ☐ Yes ☐ No

WHAT KIND OF SHOT? (I.E. CORTISONE, HYALURONIC ACID, PRP, ETC.)	HOW MANY?	WHEN WAS THE LAST ONE?	DID THEY HELP THE PAIN? ☐ Yes ☐ No

Have you had previous surgery on this knee? ☐ Yes ☐ No

BY WHO?	WHEN?	WHAT WAS DONE?

Pain Evaluation

HOW SEVERE IS THE PAIN RIGHT NOW? 0 = NONE / 10 = SEVERE PAIN (CIRCLE ONLY ONE NUMBER)	○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10	
WHEN DO YOU FEEL THE PAIN AND HOW LONG DOES IT LAST? (AM, PM, INCREASES OVER DAY, CONSTANT, ETC.)		
WHAT MOVEMENTS MAKE THE PAIN WORSE? (SQUATTING, RUNNING, EXTENDING, CUTTING, ETC)		
DO YOU HAVE PAIN THAT WAKES YOU UP FROM SLEEP? ☐ Yes ☐ No	DO YOU HAVE PAIN RIGHT NOW WHILE NOT MOVING? ☐ Yes ☐ No	
DOES THE KNEE SWELL? ☐ Yes ☐ No	DOES THE KNEE GIVE WAY? ☐ Yes ☐ No	DOES THE KNEE LOCK OR CATCH? ☐ Yes ☐ No
DOES YOUR KNEE PROBLEM LIMIT YOU ? (I.E. WORK, SPORTS, ACTIVITIES OF DAILY LIVING)		