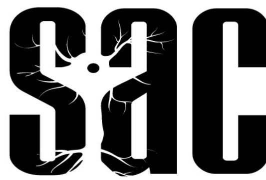
Alberto J. Panero, D.O.
Diplomate of the
American Board of PM&R
Board Certified in Sports Medicine

OFFICIAL TEAM PHYSICIAN



REGENERATIVE ORTHOPAEDICS

2801 K Street
Suite 330
Sacramento, CA 95816

Phone: (916) 732-3000
Fax: (916) 732-3022

DATE	PRIMARY CARE PHYSICIAN (PCP)	REFERRING PHYSICIAN

Patient Information

FIRST NAME	LAST NAME	SOCIAL SECURITY NO.

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

EMAIL ADDRESS	MAY WE SEND YOU FOLLOW-UP QUESTIONNAIRES VIA EMAIL? ☐ Yes ☐ No

ARE YOU EMPLOYED? ☐ Yes ☐ No	NAME OF EMPLOYER	OCCUPATION

DATE OF BIRTH	AGE	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Other

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 ☐ Self ☐ Spouse ☐ Parent ☐ Other

TYPE OF INSURANCE	☐ HMO/EPO (Name):	☐ PPO/POS/PI ☐ Med/Legal ☐ Private Pay

Secondary Insurance

INSURANCE PROVIDER	ID NUMBER	GROUP NUMBER

SUBSCRIBER NAME (FIRST, LAST)	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other

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

FIRST NAME	LAST NAME	SOCIAL SECURITY NO.

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Other	DATE OF BIRTH	SEX ☐ Male ☐ Female

FORM A: NEW PATIENT (Non-WC)

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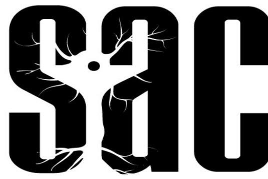

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PATIENT'S LAST NAME	PATIENT'S FIRST NAME	DATE

Card Images

PRIMARY INSURANCE CARD

SECONDARY INSURANCE CARD

PHOTO ID

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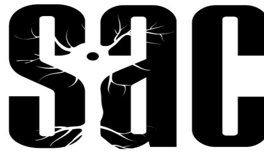

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Welcome. Please take a moment to provide us with some information about yourself.

LAST NAME	FIRST NAME	DATE	HEIGHT	WEIGHT

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 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 currently smoke ____packs/day
- ☐ I was a smoker-quit date_______
- ☐ I used to or currently drink alcohol
- ☐ I use or have used recreational drugs

PLEASE LIST ANY OTHER MEDICAL PROBLEMS OR SURGICAL PROCEDURES	DOCTOR NAME / NUMBER (IF APPLICABLE)

Allergies

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

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

ALLERGY	REACTION

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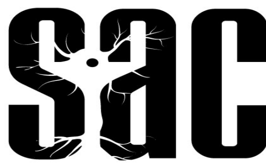

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Patient Information

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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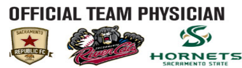

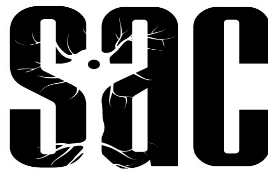

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LAST NAME	FIRST NAME	DATE

Financial Agreement

Dr. Panero's practice specializes in sports medicine and PM&R, 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. Panero 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. Panero 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. Panero accepts, and would like to pay out-of-pocket for my visit.

PATIENT/GUARDIAN SIGNATURE DATE

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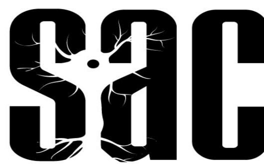

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Please initial each of the items below

Records Release

I hereby authorize Dr. Alberto Panero 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 sports medicine care 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. Alberto Panero 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. Panero. 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. Panero, 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. Panero 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. Panero'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 provider 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 items above.**

PATIENT/GUARDIAN SIGNATURE DATE