

Patient Name \_\_\_\_\_ last first middle initial nickname  Male  
 Female

Mailing Address \_\_\_\_\_ street apt. # Home Phone \_\_\_\_\_  
 \_\_\_\_\_ city state zip Day/Cell Phone \_\_\_\_\_ e-mail \_\_\_\_\_

**The federal government requires that we collect the following information:**

<b>Marital Status</b>		<b>Race</b>	<b>Ethnicity</b>
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Separated	<input type="checkbox"/> Widow/er	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Dependent	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Prefer Not to Disclose
		<input type="checkbox"/> Other _____	<input type="checkbox"/> Unknown
		<input type="checkbox"/> Black/African American	
		<input type="checkbox"/> Asian	
		<input type="checkbox"/> Prefer Not to Disclose	
		<input type="checkbox"/> Unknown	

Preferred Language \_\_\_\_\_

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Social Security# \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ last first

Referred by Dr. \_\_\_\_\_ last first Phone \_\_\_\_\_

Patient's Employer/School \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact Information \_\_\_\_\_

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Ins. Co. Name _____	Ins. Co. Name _____
Subscriber Name _____	Subscriber Name _____
Birthdate ____ / ____ / ____	Birthdate ____ / ____ / ____
Group # _____ ID # _____	Group # _____ ID # _____
Subscriber's Employer _____	Subscriber's Employer _____
Does your insurance carrier require a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**BILLING INFORMATION**

(Complete if person responsible for bill is not the patient.)

Name of Person Responsible for Bill \_\_\_\_\_ relationship \_\_\_\_\_ social security # \_\_\_\_\_

Address (if not as above) \_\_\_\_\_ street city state zip

Home Phone \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Address \_\_\_\_\_

**PREFERRED PHARMACY**

Preferred Pharmacy Name: \_\_\_\_\_ Location/# \_\_\_\_\_

2nd Preferred Pharmacy Name: \_\_\_\_\_ Location/# \_\_\_\_\_

**HOW WERE YOU RECOMMENDED TO US?**

Hospital/Emergency Room \_\_\_\_\_ Internet \_\_\_\_\_ Postcard / Mailing \_\_\_\_\_ TV / Radio \_\_\_\_\_

Friend / Family \_\_\_\_\_ Referring Doctor \_\_\_\_\_ Other \_\_\_\_\_

Seminar/Event \_\_\_\_\_ Magazine/Newspaper \_\_\_\_\_

I have read and acknowledged the Proliance Surgeons patient financial policy and authorize my insurance benefits to be paid to Orthopedic Specialists of Seattle. I consent to the release of any information, by insurance or provider, required to get my claim paid. Furthermore, I understand I am financially responsible for any balance that my insurance does not pay.

signature

date

**PATIENT MEDICAL HISTORY**

Patient Name \_\_\_\_\_ last \_\_\_\_\_ first \_\_\_\_\_ middle initial \_\_\_\_\_  
 Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender  Male  Female Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Occupation \_\_\_\_\_ Retired?  No  Yes  
 Primary Care Physician \_\_\_\_\_  None Referred by: \_\_\_\_\_  
 Is this a work related injury?  No  Yes Right or left handed: \_\_\_\_\_

**MEDICATIONS** (Please list ALL medications including prescriptions, over-the-counter medications and blood thinning medications such as Coumadin, Plavix, aspirin, etc.)  None

Medication	Dose	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

**ALLERGIES** (Please list ALL allergies including contrast dyes, metal, latex, medication or other.)  None

Name	Specify Reaction (hives, rash, breathing difficulty, anaphylaxis)
1.	
2.	
3.	
4.	
5.	

**PERSONAL MEDICAL HISTORY** (Please check if YOU currently have or had the following diseases/conditions and circle any that apply.)

- Allergy to Antibiotics (Reaction: \_\_\_\_\_)
- Anemia/Bleeding Disorder
- Anesthesia Difficulties/  
Malignant Hyperthermia
- Antibiotic Resistant Infection/MRSA
- Arthritis
- Asthma/COPD/Emphysema/  
Breathing Problems
- Cancer (Type: \_\_\_\_\_)
- Diabetes
- DVT/Pulmonary Embolism/Blood Clots
- Epilepsy/Seizures/Convulsions
- Glaucoma
- Gout
- Heart Problems/Heart Attack/  
Irregular Heartbeat/Stents
- High Blood Pressure
- HIV / HEP A/B/C
- Kidney Disease
- Liver Diseases
- Metal Allergy
- Muscular Dystrophy
- None
- Osteoporosis/Osteopenia
- Other (List: \_\_\_\_\_)
- Sleep Apnea
- Steroid Use
- Stroke/TIA
- Thyroid Disorder
- Tuberculosis
- Weakness

# PATIENT MEDICAL HISTORY

**PREVIOUS SURGERIES** (Please list ALL previous surgeries and date.)  None

Procedure / Date	Procedure / Date
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**MEDICAL FAMILY HISTORY** (Please check if anyone in your FAMILY has or had the following diseases/conditions and circle the applicable condition.)

- |  |   |
|--|---|
| <input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Epilepsy/Seizures/Convulsions<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Heart Problems/Heart Attack/Irregular Heartbeat/Stroke<br><input type="checkbox"/> DVT/Pulmonary Embolism/Blood Clots<br><input type="checkbox"/> Anemia/Bleeding Disorder<br><input type="checkbox"/> Asthma/Breathing Problems/Emphysema<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Liver Diseases/Hepatitis (Type: _____)<br><input type="checkbox"/> Kidney Problems<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Osteoporosis/Osteopenia<br><input type="checkbox"/> Cancer (Type: _____)<br><input type="checkbox"/> Metal Allergy<br><input type="checkbox"/> Other (List: _____)<br><input type="checkbox"/> Anesthesia<br><input type="checkbox"/> None |
|--|---|

**SOCIAL HISTORY**

- Do you use tobacco?     No     Yes    Packs Per Day: \_\_\_\_\_    If Quit when: \_\_\_\_\_
- Do you drink alcohol?     No     Yes    Type: \_\_\_\_\_    How Much/Often: \_\_\_\_\_
- Are you pregnant?     No     Yes     Possibly
- Current or history of drug use?     No     Yes    Type: \_\_\_\_\_ (including marijuana)
- How many children do you have? \_\_\_\_\_    Number living with you? \_\_\_\_\_

**REVIEW OF SYSTEMS** (Please check if YOU are experiencing any of the following symptoms and circle any that apply.)

- Fever/Weight Loss or Gain/Chills/Fatigue
- Sore Throat/Difficulty Swallowing/Nose Bleeds/Ear or Hearing Problems/Headache/Migraines
- Excessive Thirst or Appetite/Excessive Urination/Heat or Cold Intolerable
- Visual Difficulty/Redness/Watery Eyes
- Chest Pain/Palpitations/Fainting/Murmurs
- Cough/Sputum Production/Snoring/Short of Breath/Wheezing
- Blood in Stool/Loss of Bowel Control/Nausea/Vomiting/Ulcers
- Bladder/Urological Problems/Painful Urination/Prostate Problems
- Bleeding Problems/Easy Bruising
- Joint Swelling/Stiffness/Redness/Heat/Muscle Pain/Swelling
- Depression/Nervousness/Anxiety/Hallucinations
- Skin Disorders/Rash/Poor Healing/Redness

The above information is true and correct to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

M.D. Review \_\_\_\_\_ Date \_\_\_\_\_

# INCIDENT REPORT

Please provide information regarding your orthopedic condition

PATIENT: \_\_\_\_\_ WHERE OCCURRED:  Home  
DATE OF INJURY/ONSET: \_\_\_\_\_  School  
BODY PART: Left (  ) Right (  )  Work  
\_\_\_\_\_  
\_\_\_\_\_  
 Auto  
 Other:

Briefly describe the incident/injury or what caused onset of symptoms:

\_\_\_\_\_  
\_\_\_\_\_

## INSURANCE COVERAGE

FOR THIS INCIDENT-INJURY-CONDITION

Regence Subscribers SS# \_\_\_\_\_  
 Medicare Subscribers SS# \_\_\_\_\_  
 Premera Blue Cross of WA and AK Subscribers SS# \_\_\_\_\_

Worker's Compensation  
 Department of Labor and Industries (Olympia)  
\*\*Claim# \_\_\_\_\_ DOI \_\_\_\_\_

Self Insured Company  
\*\*Claim# \_\_\_\_\_ DOI \_\_\_\_\_

Name of Company \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Contact phone # \_\_\_\_\_

Auto Related  
 Covered under own PIP  
\*\*Claim# \_\_\_\_\_ DOI \_\_\_\_\_

Name of Company \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Contact phone # \_\_\_\_\_

Subrogation through private health insurance

Other: \_\_\_\_\_

Your insurance contract includes a subrogation provision. "Subrogation" means that your insurance company makes any payments on your behalf for injuries caused by another party who may be liable for those injuries, your insurance company is entitled to recover those payments from the other party. As a condition of these payments, the subscriber agrees to cooperate with your insurance company in its efforts to recover the cost paid on behalf of the injured party. I understand that if I or any of my dependents have been injured by another party, the benefits of my contract will be available to the injured person, subject to the exclusions and limitations of the contract. I agree to cooperate with my insurance company in its subrogation and reimbursement rights as stated in the contract. My insurance company reserves the right to determine payment of attorney fees for recovery of its financial interest in this claim. I understand I am not entitled to keep that portion of the settlement which represents reimbursement of the amount my insurance company paid towards my medical benefits except as determined by applicable law.

I certify that the information on this form is true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## RELEASE OF INFORMATION

If you are unavailable, may detailed messages be left for you on home answering machines, personal voice mail, etc? Yes \_\_\_\_ No \_\_\_\_

If yes, please give the appropriate numbers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

May we have standing permission to discuss your health issues with one or more family members? You do not need to allow us to speak to anyone but realize if your family member or caregiver calls in for any reason, they will not be able to receive information unless written permission is given.

Orthopedic Specialists of Seattle may share information with:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You may revoke these permissions at any time and to the extent information has not already been shared we will comply.

\_\_\_\_\_  
Patient or patient representative signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship if patient representative

Please provide email if you would like to receive newsletters.

\_\_\_\_\_

I decline to provide



## NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

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We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship  
(parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record.

## HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

### **We are required by law to:**

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

### **How we may use and disclose health information about you:**

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

### **Your rights regarding Health Information about you:**

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (*full Notice is available upon request*)

### **Changes to this Notice:.**

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

### **Complaints:**

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

### **Acknowledgement of Receipt of this Notice:**

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.