OSS **Orthopedic Specialists of Seattle**

a division of PS PROLIANCE SURGEONS®

PATIENT REGISTRATION

Patient Name _____ ☐ Male ☐ Female
last first middle initial nickname

Mailing Address _____ Home Phone _____
street apt. #

_____ Day/Cell Phone _____
city state zip

The federal government requires that we collect the following information:

Marital Status
☐ Single ☐ Married
☐ Separated ☐ Widow/er
☐ Dependent ☐ Domestic Partner

Race
☐ White/Caucasian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Prefer Not to Disclose
☐ Other _____ ☐ Unknown

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer Not to Disclose
☐ Unknown

Preferred Language _____

Birthdate ____/____/____ Age _____ Social Security# _____

Primary Care Physician _____
last first

Referred by Dr. _____ Phone _____
last first

Referred by Patient/Other _____ Phone _____
last first

Patient's Employer/School _____ Phone _____

Parents/Spouse/Domestic Partner Name _____ Employer _____ Phone _____

Emergency Contact Information _____

PRIMARY INSURANCE

Ins. Co. Name _____

Subscriber Name _____

Birthdate ____/____/____

Group # _____ ID # _____

Subscriber's Employer _____

Does your insurance carrier require a referral? ☐ Yes ☐ No

ANY OTHER INSURANCE

Ins. Co. Name _____

Subscriber Name _____

Birthdate ____/____/____

Group # _____ ID # _____

Subscriber's Employer _____

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? Emergency Room _____ Internet _____ Postcard / Mailing _____ TV / Radio _____

Friend / Family _____ Referring Doctor _____ Other _____

I authorize my insurance benefits to be paid to Orthopedic Specialists of Seattle. I understand I am financially responsible for any balance that my insurance does not pay. I authorize the doctor or insurance company to release any information required for this claim.

_____ _____
signature date

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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

REV 3/13

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.)

☐ Glaucoma
☐ Epilepsy/Seizures/Convulsions
☐ High Blood Pressure
☐ Heart Problems/Heart Attack/Irregular Heartbeat/Stroke
☐ DVT/Pulmonary Embolism/Blood Clots
☐ Anemia/Bleeding Disorder
☐ Asthma/Breathing Problems/Emphysema
☐ Diabetes
☐ Thyroid Disorder
☐ Liver Diseases/Hepatitis (Type:_____)
☐ Kidney Problems
☐ Arthritis
☐ Gout
☐ Osteoporosis/Osteopenia
☐ Cancer (Type:_____)
☐ Metal Allergy
☐ Other (List:_____)
☐ Anesthesia
☐ 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: _____

SOC Seattle Orthopedic Center

a service of PROLIANCE SURGEONS®

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Fax (206) 633-6073

Physical Therapy
(206) 633-8100
Fax (206) 632-1420

MRI
(206) 633-8100
Fax (206) 632-1657

Herbert R. Clark, M.D.
Sports Medicine, Arthroscopy, Joint Reconstruction

Philip R. Downer, M.D.
Orthopedic & Sports Medicine
Hip Preservation & Replacement

Jonathan L. Franklin, M.D.
Orthopedic & Sports Medicine
Knee & Shoulder Arthroscopy

Charles A. Peterson II, M.D.
Sports Medicine
Orthopaedic & Fracture Surgery
Total Joint Replacement

Mark A. Reed, M.D.
Orthopedic & Sports Medicine
Foot & Ankle Surgery

Scott D. Ruhlman, M.D.
Orthopedic & Sports Medicine
Hand, Shoulder & Elbow Surgery

Joel A. Shapiro, M.D.
Orthopedic & Sports Medicine
Shoulder & Elbow Surgery

J. Michael Watt, M.D.
Orthopedic & Sports Medicine
Joint Replacement Surgery

Wayne M. Weil, M.D.
Orthopedic & Sports Medicine
Hand & Microvascular Surgery

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.

Seattle Orthopedic Center 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 ☐

PROLIANCE SURGEONS®

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

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.

Last updated: August 17, 2006

PROLIANCE SURGEONS®

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.