



PHWE

PROLIANCE HAND, WRIST & ELBOW PHYSICIANS

WORK AGAIN, PLAY AGAIN!

DEMOGRAPHICS

| | | | | | | |
|---|--|--|---------------------|------------|-----------------------|--------------|
| Patient LAST Name: | | Patient FIRST Name: | | | MI: | |
| Date of Birth: | Age: | M/F | Email: | | | |
| Address: | | | | | | |
| City: | State: | Zip: | SS#: | | | |
| Primary Phone: () | | <input type="checkbox"/> ok to leave msg | ()single | ()married | ()Divorced/Separated | ()Dependent |
| Other Phone: () | | <input type="checkbox"/> ok to leave msg | Parent/Spouse Name: | | | |
| Are you Right or Left Handed? | | Referring Provider: | | | | |
| | | Primary Care Provider: | | | | |
| [With our recent mandated conversion to electronic medical record, we are now required to survey the following patient demographics.] | | | | | | |
| What language do you speak? _____ | | | | | | |
| Race: | | | | | | |
| <input type="checkbox"/> American Indian or Alaska | <input type="checkbox"/> White or Caucasian | | | | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Pacific Islander | | | | | |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other/Undetermined | | | | | |
| Ethnicity: | | | | | | |
| <input type="checkbox"/> Hispanic or Latino | | | | | | |
| <input type="checkbox"/> Non-Hispanic or Latino | | | | | | |

BILLING INFORMATION

| | | | | | |
|--|--------------------|--|-------------------------|-----------------|--------|
| Name of Person Responsible for Bill: | | | | | |
| Address (if not above): | | | | City: | State: |
| Zip: | Primary Phone: () | | Other Phone: () | | |
| Is this a work related injury? (required) Y / N | | If yes, did you file a Workers Comp Claim? Y / N | | Claim #: | |
| Name and Address of self-insured company: | | | | Date of Injury: | |
| | | | | Phone: () | |
| PRIMARY INSURANCE: | | | OTHER INSURANCE: | | |
| Ins. Co. Name: | | | Ins. Co. Name: | | |
| Subscriber Name: | | | Subscriber Name: | | |
| Date of Birth: | | | Date of Birth: | | |
| ID #: | Grp #: | ID #: | Grp #: | | |
| Subscriber's Employer: | | | Subscriber's Employer: | | |
| Does your insurance carrier require a referral? : Y N (If yes, it is your responsibility to obtain a referral from your primary care provider.) | | | | | |
| I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me by any of the physicians at Proliance Surgeons. I authorize any holder of medical information about me to release to HCFA and its agents or to my other insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment and I accept financial responsibility for non-covered services. | | | | | |
| ***SIGNATURE: _____ | | | DATE: _____ | | |



Financial Policy

Our credit and collection policy is in place to retain financial resources and maintain excellent health care for our patients and community.

PHWE will bill your insurance, however, it is your responsibility to verify your benefits and ensure your visits will be covered under your policy and that any referral or authorization is in place before you are seen. Services provided from our satellite offices could be subject to out of network benefits resulting in higher patient responsibility. You will need to provide all information necessary for PHWE to bill your insurance carrier. This includes: **Subscriber’s name, date of birth, social security number, complete name and billing address of your insurance company and the ID and group numbers.** Co-Pays are due at the time of service. This is a requirement by the contract you have with your insurance company. Deductible or balances owed are due within 30 days of the statement you receive. Once a balance is carried over 30 days there will be a monthly late fee of \$10.25. NSF checks will be subject to a \$40 processing fee.

In the event of an insurance claim rejection or denial, the patient is responsible for payment for all services provided. Third party claims, no insurance coverage and those involving attorneys negotiating settlements will be expected to pay at the time of service. PHWE will only mail statements to the guarantor address.

Notice of Privacy Practices- Acknowledgement

We keep a record of the health care services we provide you. We will not disclose your record to others without your signed consent or the law authorizes us to do so. You may ask to see, copy, or correct your records. To get more information about your records, call the office to the location you were seen 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 that I have declined to accept the complete Notice of Privacy Practices and instead asked to receive only the Short Form Notice of Privacy Practices. I have been made aware that the complete Notice of Privacy Practices is available to me at any time. I can request a copy; one is available and on display in the waiting room, and it is available on the Proliance Surgeons web site at www.proliancesurgeons.com.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient
(Parent, legal guardian, Personal Representative)

Relationship

This form will be retained in your medical record.

Last update: March 2016



Patient Health History Form

Phone: (425) 823 - 4224 Fax: (425) 820 - 8975

| DEMOGRAPHICS | |
|--|---------------------------------|
| Patient Name: _____ | Height: _____ Weight: _____ |
| Date of Birth: _____ | Age: _____ |
| Male: <input type="radio"/> Female: <input type="radio"/> (Pregnant: No <input type="radio"/> Yes <input type="radio"/> Unsure <input type="radio"/>) | Office Use: BP: _____ HR: _____ |
| Referring Physician: _____ | |
| Primary Care Physician: _____ | |
| What are you being seen for today? _____ | |
| When was your last flu shot? _____ | |
| If you are diabetic, when was your last eye exam? _____ | |
| If you are over 50 years old, when was your last Colonoscopy? _____ | |
| If you are over 65 years old, when was your last Pneumonia vaccination? _____ | |
| Women only: If you are 21-64 years of age, when was your last Pap Smear? _____ | |
| If you are 40-69 years of age, when was your last Mammogram? _____ | |

| PAST MEDICAL HISTORY | | | |
|---|---------|---|---------|
| | Explain | | Explain |
| <input type="radio"/> Anemia | | <input type="radio"/> Kidney/ bladder infections | |
| <input type="radio"/> Arthritis (“wear and tear”) | | <input type="radio"/> Kidney stones | |
| <input type="radio"/> Asthma | | <input type="radio"/> Kidney problems, other | |
| <input type="radio"/> Bad teeth | | <input type="radio"/> Liver problems | |
| <input type="radio"/> Bleeding problems | | <input type="radio"/> Lupus | |
| <input type="radio"/> Blood clots | | <input type="radio"/> MRSA | |
| <input type="radio"/> Cancer | | <input type="radio"/> Osteoporosis or osteopenia | |
| <input type="radio"/> COPD/ Emphysema | | <input type="radio"/> Prostate problems | |
| <input type="radio"/> Depression | | <input type="radio"/> Psoriasis | |
| <input type="radio"/> Diabetes | | <input type="radio"/> Psychiatric problems | |
| <input type="radio"/> Drug or alcohol problems | | <input type="radio"/> Rheumatoid arthritis | |
| <input type="radio"/> GERD/ reflux | | <input type="radio"/> Scoliosis | |
| <input type="radio"/> Glaucoma | | <input type="radio"/> Seizures | |
| <input type="radio"/> Gout | | <input type="radio"/> Stroke | |
| <input type="radio"/> Hearing problems | | <input type="radio"/> Thyroid problems | |
| <input type="radio"/> Heart attack | | <input type="radio"/> Tuberculosis | |
| <input type="radio"/> Heart disease | | <input type="radio"/> Ulcerative colitis/ Crohn’s | |
| <input type="radio"/> Hepatitis | | <input type="radio"/> Ulcers | |
| <input type="radio"/> High blood pressure | | <input type="radio"/> Other: | |
| <input type="radio"/> HIV positive/ AIDS | | | |

PHWE Patient Health History Form- Page 2

PAST SURGICAL HISTORY

Please list the surgical procedures you have undergone:

| Date of Surgery | Type of Surgery | Describe the Recovery |
|-----------------|-----------------|-----------------------|
| 1) _____ | _____ | _____ |
| 2) _____ | _____ | _____ |
| 3) _____ | _____ | _____ |
| 4) _____ | _____ | _____ |
| 5) _____ | _____ | _____ |
| 6) _____ | _____ | _____ |
| 7) _____ | _____ | _____ |

Have you ever had history of anemia or blood disorder? No Yes, explain _____

Have you or any relatives had problems with anesthesia? No Yes, explain _____

Have you ever had an EKG? No Yes, when/ where? _____

Do you get shortness of breath when climbing more than 2 flights of stairs? No Yes

If you are over the age of 65, please answer:

Have you fallen in the last year or feel unsteady on your feet? Yes No

If you answered yes, please complete the following:

| | | |
|--|---------------------------|--------------------------|
| Have you fallen in the last year? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you feel unsteady on your feet? | <input type="radio"/> Yes | <input type="radio"/> No |
| History of broken bones as an adult? | <input type="radio"/> Yes | <input type="radio"/> No |
| Fallen more than twice in the last year? | <input type="radio"/> Yes | <input type="radio"/> No |
| Have you sustained injuries from any of those falls? | <input type="radio"/> Yes | <input type="radio"/> No |
| Take calcium and/or vitamin D supplements? | <input type="radio"/> Yes | <input type="radio"/> No |
| Currently on osteoporosis medication? | <input type="radio"/> Yes | <input type="radio"/> No |

MEDICATIONS

Please list ALL medications and doses that you are CURRENTLY taking (this includes birth control pills, hormones, IUDs, vitamins and herbal supplements):

| Medication | Dose/ Strength | # Pills per Day | Reason |
|------------|----------------|-----------------|--------|
| 1) _____ | _____ | _____ | _____ |
| 2) _____ | _____ | _____ | _____ |
| 3) _____ | _____ | _____ | _____ |
| 4) _____ | _____ | _____ | _____ |
| 5) _____ | _____ | _____ | _____ |
| 6) _____ | _____ | _____ | _____ |
| 7) _____ | _____ | _____ | _____ |
| 8) _____ | _____ | _____ | _____ |
| 9) _____ | _____ | _____ | _____ |

PHWE Patient Health History Form- Page 3

| ALLERGIES | | | |
|--|----------|---|----------|
| <input type="radio"/> I have no allergies to medication. | | | |
| Medication | Reaction | Medication | Reaction |
| 1) _____ | _____ | 4) _____ | _____ |
| 2) _____ | _____ | 5) _____ | _____ |
| 3) _____ | _____ | 6) _____ | _____ |
| Latex allergy? <input type="radio"/> No <input type="radio"/> Yes | | Please list below any pain medications you do not tolerate. | |
| Food allergy? <input type="radio"/> No <input type="radio"/> Yes, type _____ | | | |

| FAMILY HISTORY: Please check any conditions associated with your immediate family members | | | | | | | | | | | | | | | |
|---|--------|--------|-----|----------|---------|--------|-------|----------------------------------|--------|--------|-----|----------|---------|--------|-------|
| | Mother | Father | Son | Daughter | Brother | Sister | Other | | Mother | Father | Son | Daughter | Brother | Sister | Other |
| Anesthesia Problems | | | | | | | | Drug & Alcohol Addiction | | | | | | | |
| Arthritis | | | | | | | | Heart Disease | | | | | | | |
| Back Pain | | | | | | | | High Blood Pressure/Hypertension | | | | | | | |
| Blood Clots | | | | | | | | Malignant Hyperthermia | | | | | | | |
| Cancer: Breast | | | | | | | | Osteoporosis / Osteopenia | | | | | | | |
| Cancer: Colon | | | | | | | | Rheumatoid Arthritis | | | | | | | |
| Cancer: _____ | | | | | | | | Sleep Apnea | | | | | | | |
| COPD/Emphysema | | | | | | | | Stroke | | | | | | | |
| Depression | | | | | | | | Other: _____ | | | | | | | |
| Diabetes | | | | | | | | Other: _____ | | | | | | | |

| SOCIAL HISTORY | |
|---|---|
| Do you use tobacco products? <input type="radio"/> Yes, I smoke _____ packs per day <input type="radio"/> Yes, I currently chew tobacco/ snuff <input type="radio"/> No, I quit smoking/ chewing _____ years _____ months ago <input type="radio"/> No, I have never used tobacco products | Current situation? <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Single <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Living with significant other |
| Do you consume alcoholic beverages (e.g., beer, wine, liquor)? <input type="radio"/> No <input type="radio"/> Yes, type: _____ amount/ week: _____ | Do you have children? <input type="radio"/> No <input type="radio"/> Yes, how many? _____ |
| Do you use illicit drugs? <input type="radio"/> No <input type="radio"/> Yes, type: _____ | |
| Do you live: <input type="radio"/> alone <input type="radio"/> with spouse, family, and/ or friend(s) <input type="radio"/> assisted living | |
| Have you had a recent change in a significant relationship in the last year or other stress? <input type="radio"/> No <input type="radio"/> Yes If yes, please explain: _____ | |

| WORK HISTORY |
|--|
| What is your occupation or previous one if currently not working? _____ Briefly describe your job: _____ Name of employer: _____ Last date worked: _____ |
| Please mark ONE statement that best describes your current employment situation: <input type="radio"/> currently working <input type="radio"/> student <input type="radio"/> disabled/ retired from a health problem (NOT from an orthopedic or spine problem) <input type="radio"/> on paid leave <input type="radio"/> homemaker <input type="radio"/> on unpaid leave <input type="radio"/> disabled/ retired from an orthopedic and/or spine problem <input type="radio"/> retired (not due to health) <input type="radio"/> unemployed <input type="radio"/> other, please specify _____ |

PHWE Patient Health History Form- Page 4

REVIEW OF SYSTEMS

Please mark the circle next to ANY symptoms you have experienced in the past 6 months:

| | | | |
|---|---|--|---|
| Constitutional | Cardiovascular | Gastrointestinal | Skin |
| <input type="radio"/> recent weight gain >10 lbs. | <input type="radio"/> heart trouble | <input type="radio"/> nausea/ vomiting | <input type="radio"/> rashes |
| <input type="radio"/> recent weight loss >10 lbs. | <input type="radio"/> chest pain | <input type="radio"/> constipation | <input type="radio"/> psoriasis |
| <input type="radio"/> loss of appetite | <input type="radio"/> heart murmur | <input type="radio"/> diarrhea | <input type="radio"/> bruise easily |
| <input type="radio"/> fatigue | <input type="radio"/> palpitations | <input type="radio"/> blood in your stool | <input type="radio"/> abnormal lumps |
| <input type="radio"/> insomnia | <input type="radio"/> irregular heartbeat | <input type="radio"/> loss of bowel control | <input type="radio"/> painful breasts |
| <input type="radio"/> fever/ chills | <input type="radio"/> varicose veins | <input type="radio"/> abdominal pain | <input type="radio"/> change in skin color |
| <input type="radio"/> night sweats | <input type="radio"/> swelling of the feet/ ankles | | <input type="radio"/> change in hair or nails |
| | | Genitourinary | |
| Eyes/ Ears | Respiratory | <input type="radio"/> blood in your urine | Neurologic |
| <input type="radio"/> eye disease | <input type="radio"/> shortness of breath | <input type="radio"/> increased frequency of urination | <input type="radio"/> headache/ migraine |
| <input type="radio"/> glasses or contacts | <input type="radio"/> wheezing | <input type="radio"/> urgency of urination | <input type="radio"/> dizziness |
| <input type="radio"/> blurred or double vision | <input type="radio"/> chronic cough | <input type="radio"/> painful urination | <input type="radio"/> convulsions/ seizures |
| <input type="radio"/> vision loss | <input type="radio"/> COPD/ emphysema | <input type="radio"/> loss of bladder control | <input type="radio"/> loss of consciousness |
| <input type="radio"/> hearing loss | | <input type="radio"/> kidney stones | |
| <input type="radio"/> ringing in the ears | Hematologic | <input type="radio"/> incontinence | Mental Health |
| | <input type="radio"/> bleeding tendency | <input type="radio"/> sexual difficulty | <input type="radio"/> depression |
| Nose | <input type="radio"/> anemia | | <input type="radio"/> nervousness |
| <input type="radio"/> sinus problems | <input type="radio"/> recurrent infections | Musculoskeletal | <input type="radio"/> hallucinations |
| <input type="radio"/> nose bleeds | | <input type="radio"/> fractures/ sprains | <input type="radio"/> anxiety |
| | Endocrine | <input type="radio"/> osteoporosis | <input type="radio"/> unusual stress in home life |
| Throat/ Mouth | <input type="radio"/> thyroid problems | <input type="radio"/> joint swelling | <input type="radio"/> unusual stress in work life |
| <input type="radio"/> sore throat | <input type="radio"/> heat or cold intolerance | <input type="radio"/> joint pain | Other: |
| <input type="radio"/> mouth sores | <input type="radio"/> excessive thirst/ appetite | <input type="radio"/> weakness of muscles or joints | |
| <input type="radio"/> hoarseness | <input type="radio"/> diabetes | <input type="radio"/> muscle pain or cramps | |
| <input type="radio"/> sleep apnea | <input type="radio"/> glandular or hormone problems | <input type="radio"/> back pain | |
| <input type="radio"/> swollen glands in the neck | | <input type="radio"/> difficulty walking | |

I have not had ANY of the above symptoms in the last 6 months.

SIGNATURE

Patient's signature: _____ Date: _____

Please print name: _____

Physician's signature: _____ Date: _____

Please print name: _____