PHWE | PROLIANCE HAND, WRIST & ELBOW PHYSICIANS

WORK AGAIN, PLAY AGAIN!

DEMOGRAPHICS

Patient LAST Name:		Patient FIRST Name:		M I:
Date of Birth:	Age:	M/F	Email:	
Address:				
City:	State:	Zip:	SS#:	
Primary Phone: ( ) ☐ ok to leave msg		( )single ( )married ( )Divorced/Separated ( )Dependent		
Other Phone: ( ) ☐ 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:

☐ American Indian or Alaska
☐ Asian
☐ Black or African American
☐ White or Caucasian
☐ Native Hawaiian or Pacific Islander
☐ Other/Undetermined

Ethnicity:

☐ Hispanic or Latino
☐ 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:** _____

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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 Relationship
(Parent, legal guardian, Personal Representative)

This form will be retained in your medical record.
Last update: March 2016

PHWE

Patient Health History Form

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

DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____

Male: ○ Female: ○ (Pregnant: No ○ Yes ○ Unsure ○)

Height: _____ Weight: _____

Age: _____

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
○ Anemia		○ Kidney/ bladder infections	
○ Arthritis (“wear and tear”)		○ Kidney stones	
○ Asthma		○ Kidney problems, other	
○ Bad teeth		○ Liver problems	
○ Bleeding problems		○ Lupus	
○ Blood clots		○ MRSA	
○ Cancer		○ Osteoporosis or osteopenia	
○ COPD/ Emphysema		○ Prostate problems	
○ Depression		○ Psoriasis	
○ Diabetes		○ Psychiatric problems	
○ Drug or alcohol problems		○ Rheumatoid arthritis	
○ GERD/ reflux		○ Scoliosis	
○ Glaucoma		○ Seizures	
○ Gout		○ Stroke	
○ Hearing problems		○ Thyroid problems	
○ Heart attack		○ Tuberculosis	
○ Heart disease		○ Ulcerative colitis/ Crohn’s	
○ Hepatitis		○ Ulcers	
○ High blood pressure		○ Other:	
○ 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)		

Have you ever had history of anemia or blood disorder? O No O Yes, explain_____

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

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

Have you ever had a MRSA infection?_____

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

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

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

If you answered yes, please complete the following:

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

○ I have no allergies to medication.

Medication	Reaction	Medication	Reaction
1) _____	_____	4) _____	_____
2) _____	_____	5) _____	_____
3) _____	_____	6) _____	_____

Latex allergy? ○ No ○ Yes

Food allergy? ○ No ○ Yes, type_____

Please list below any pain medications you do not tolerate.

_____

FAMILY HISTORY: *Please check any conditions associated with your immediate family members*

	Mother	Father	Son	Daughter	Brother	Sister	Other
Anesthesia Problems							
Arthritis							
Back Pain							
Blood Clots							
Cancer: Breast							
Cancer: Colon							
Cancer: _____							
COPD/Emphysema							
Depression							
Diabetes							

	Mother	Father	Son	Daughter	Brother	Sister	Other
Drug & Alcohol Addiction							
Heart Disease							
High Blood Pressure/Hypertension							
Malignant Hyperthermia							
Osteoporosis / Osteopenia							
Rheumatoid Arthritis							
Sleep Apnea							
Stroke							
Other: _____							
Other: _____							

SOCIAL HISTORY

Do you use tobacco products?

○ Yes, I smoke_____packs per day

○ Yes, I currently chew tobacco/ snuff

○ No, I quit smoking/ chewing _____years_____months ago

○ No, I have never used tobacco products

Current situation?

○ Married ○ Divorced

○ Single ○ Widowed

○ Separated

○ Living with significant other

Do you consume alcoholic beverages (e.g., beer, wine, liquor)?

○ No ○ Yes, type: _____amount/ week: _____

Do you use illicit drugs? ○ No ○ Yes, type: _____

Do you have children?

○ No ○ Yes, how many? _____

Do you live: ○ alone ○ with spouse, family, and/ or friend(s) ○ assisted living

Have you had a recent change in a significant relationship in the last year or other stress? ○ No ○ 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:

○ currently working
○ on paid leave
○ on unpaid leave
○ unemployed
○ student
○ homemaker
○ disabled/ retired from an orthopedic and/or spine problem
○ disabled/ retired from a health problem (NOT from an orthopedic or spine problem)
○ retired (not due to health)
○ 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**
○ recent weight gain >10 lbs.	○ heart trouble	○ nausea/ vomiting	○ rashes
○ recent weight loss >10 lbs.	○ chest pain	○ constipation	○ psoriasis
○ loss of appetite	○ heart murmur	○ diarrhea	○ bruise easily
○ fatigue	○ palpitations	○ blood in your stool	○ abnormal lumps
○ insomnia	○ irregular heartbeat	○ loss of bowel control	○ painful breasts
○ fever/ chills	○ varicose veins	○ abdominal pain	○ change in skin color
○ night sweats	○ swelling of the feet/ ankles		○ change in hair or nails
		Genitourinary	
Eyes/ Ears	**Respiratory**	○ blood in your urine	**Neurologic**
○ eye disease	○ shortness of breath	○ increased frequency of urination	○ headache/ migraine
○ glasses or contacts	○ wheezing	○ urgency of urination	○ dizziness
○ blurred or double vision	○ chronic cough	○ painful urination	○ convulsions/ seizures
○ vision loss	○ COPD/ emphysema	○ loss of bladder control	○ loss of consciousness
○ hearing loss		○ kidney stones	
○ ringing in the ears	**Hematologic**	○ incontinence	**Mental Health**
	○ bleeding tendency	○ sexual difficulty	○ depression
Nose	○ anemia		○ nervousness
○ sinus problems	○ recurrent infections	**Musculoskeletal**	○ hallucinations
○ nose bleeds		○ fractures/ sprains	○ anxiety
	Endocrine	○ osteoporosis	○ unusual stress in home life
Throat/ Mouth	○ thyroid problems	○ joint swelling	○ unusual stress in work life
○ sore throat	○ heat or cold intolerance	○ joint pain	**Other:**
○ mouth sores	○ excessive thirst/ appetite	○ weakness of muscles or joints	
○ hoarseness	○ diabetes	○ muscle pain or cramps	
○ sleep apnea	○ glandular or hormone problems	○ back pain	
○ swollen glands in the neck		○ 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: _____