STRAIT ORTHOPEDIC SPECIALISTS, P.S.

Patient Registration (Please Print)

832 Georgiana St.
Port Angeles, WA 98362
360-457-0804

Confidential Patient Information

Patient's Name_____ Marital Status: S M W Other
last first mi

Address_____
street city state zip

Home Phone _____ Cell Phone_____ Work Phone_____

Birthdate_____ Social Security #_____ **Language**: _____

Please circle one
Race: Caucasian, African American, Native American, Asian, Other, Declined

Please circle one
Ethnicity: Hispanic, Non-Hispanic, Declined

If Patient is a minor, give parent's or guardian's name_____

Responsible Party Information

Responsible Party Name_____
last first mi

Mailing Address_____
street city state zip

Residence Address_____
street city state zip

Home Phone _____ Work Phone_____ Cell Phone _____

Social Security # _____ Birthdate_____ Relationship to Patient_____

Employer_____ **Occupation**_____ No. Yrs. Employed _____

Spouse's Name _____

Employer_____ Occupation_____ No. Yrs. Employed _____

Social Security # _____ Birthdate_____ Work Phone_____

Workers' Comp Information

To avoid potential denial of claims by your insurance please complete the following information in full. We will scan a copy of your insurance card(s) to assist in the processing of your claim.

No. of years employed _____

Is This a Workers' Compensation Claim? ❑ Yes ❑ No Claim#_____ Date of Injury _____

Workers' Comp Carrier Name: _____

Name of Claims Manager _____ Phone #_____ Place of Injury _____

Address_____ City_____ State_____ Zip_____

All self insured workers' comp addresses must be filled out in full.

Insurance Information

Primary Insurance _____ ID#_____ Group #_____

Address_____ City_____ State_____ Zip_____

Subscriber's Name_____ Subscriber's Date of Birth_____ Rel. to insured_____

Secondary Insurance_____ ID#_____ Group #_____

Address_____ City_____ State_____ Zip_____

Subscriber's Name_____ Subscriber's Date of Birth_____ Rel. to insured_____

Physician Information

Referring Physician_____ Phone #_____

Primary Care Physician _____ Phone #_____

Emergency Contact

Name of nearest relative (or friend) ***not living with you:***_____

Phone #_____ Relationship _____

Signature

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered.

Patient, Parent or Guardian X_____ Date

Medical History

Date:_____

Patient Name:_____

Reasons you are seeing the doctor today? ❑ Right ❑ Left _____

Current problem is a result of : ❑ Car Accident ❑ Work accident ❑ Other. Check all that apply.

Medications	**Dose**	**Reason for Medication**

Medication Allergies: **Latex Allergy?** □ Yes □ No **Reaction**

_____ _____

_____ _____

_____ _____

What pharmacy do you prefer? When was your last Tetnus vaccination?

Are you currently having problems or have you had any problems with the following?

	Yes	No	Describe all **Yes** responses		Yes	No	Describe all **Yes** responses
Fever	❑	❑		Psychiatric	❑	❑	
Weight Loss	❑	❑		Thyroid/Endocrine	❑	❑	
GERD	❑	❑		Diabetes	❑	❑	
Eyes, Ears, Nose or Throat	❑	❑		Bleeding Disorder	❑	❑	
Heart Disease	❑	❑		Immune System	❑	❑	
High Blood Pressure	❑	❑		Cancer	❑	❑	
High Cholesterol	❑	❑		Osteoarthritis	❑	❑	
Lung Disease	❑	❑		Rheumatoid Arthritis	❑	❑	
Asthma	❑	❑		Fibromyalgia	❑	❑	
Sleep Apnea / CPAP?	❑	❑		Hepatitis	❑	❑	
Urinary/Prostate	❑	❑		Tuberculosis	❑	❑	
Skin	❑	❑		HIV	❑	❑	
Stroke/Brain injury/Seizures	❑	❑		MRSA	❑	❑	

Past Medical History

Surgeries:	Year	Complications:

Any Hospitalizations? _____

Any Anesthesia Problems? ❑Yes ❑No If yes, please explain _____

Family History

Has anyone in your family had any of the following?

	Yes	No	Who?
Diabetes	❑	❑	
Bleeding Disorders	❑	❑	
Anesthesia Problems	❑	❑	

Social History

❑ Right handed ❑ Left Handed

❑ Single ❑ Married ❑ Widowed

Children? ❑ Yes ❑ No How many? _____

Do you live alone? ❑ Yes ❑ No

Social History, Cont.

Smoke currently? ❑ Yes ❑ No ____ Packs per day for ___ yrs

Previously smoked? ❑ Yes ❑ No ____ Packs per day for ___ yrs

How long ago did you quit? _____ years

Alcohol use: ❑ Yes ❑ No How many drinks per week?___

History of substance abuse? ❑ Yes ❑ No What?_____

IV drug use: ❑ Yes ❑ No

Are you currently living in a nursing home? ❑ Yes ❑ No

Do you work? ❑ Yes ❑ No Occupation _____

Former occupation if retired _____

Patient Signature: X _____ Date: _____

PATIENT AGREEMENT

STRAIT ORTHOPEDIC SPECIALISTS

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Strait Orthopedic Specialists to request on my behalf and to collect directly all public and private insurance coverage due for products and services supplied by Strait Orthopedic Specialists. In the event that benefits are paid directly to me, I will endorse to Strait Orthopedic Specialists all checks for such payments.

EXTENDED MEDICARE ASSIGNMENT: I certify that the information given by me under Medicare (Title XVIII, Social Security Act) and/or any other insurance is correct.

1. The Patient, if physically or mentally competent, must sign on his behalf. If he cannot sign for himself, a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of signatory's authority should be stated, e.g. Social Security Representative Payee, court appointed guardian, etc.
2. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 form and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may upon conviction be subject to fine and imprisonment under federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information needed to process related Medicare claims. He further permits a copy of the authorization to be used in place of the original.
3. On assigned claims, the provider agrees to accept the Medicare Carrier's allowable amount as the full charge for covered services; the patient is responsible for the deductible, co-insurance and non-covered services. This authorization may be canceled by mutual agreement of the provider and the patient at any time by written notice to the Medicare carrier. I request payment under the Medical Insurance Part of Medicare to be made directly to Strait Orthopedic Specialists for services furnished to me during the effective period of this authorization. I have read and I agree to the release of information as specified in paragraph 2 above.

MEDICAL CONSENT: I give my consent for all routine, usual and customary tests, exams and procedures as prescribed by the attending physician of Strait Orthopedic Specialists for myself or my minor child or as legal guardian.

RELEASE OF MEDICAL INFORMATION: I authorize Strait Orthopedic Specialists to release any health care information necessary to facilitate processing of claims, audit of payments and routine professional medical communication with my referring and/or primary care physicians. Strait Orthopedic Specialists maintains a record of health care services provided to you. You may ask to see and obtain copies of that record at any time. Strait Orthopedic Specialists will otherwise not disclose your records or personal information to others unless you direct us to in writing or unless required by law.

THE PATIENT HEREBY AGREES THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED: I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or any subsequent visits or procedures, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and interest for overdue payments. I hereby authorize Strait Orthopedic Specialists to release information necessary to secure payment of benefits or fees. **I also acknowledge that it is my responsibility to obtain a referral if my insurance company or HMO requires one.**

X_____

Signature of Patient/Guarantor Date

_____

Printed Name of Patient

HIPAA Privacy Policy: By my signature below I acknowledge receipt of the notice of Privacy Practices of Strait Orthopedic Specialists, P.S.

X_____ _____ _____

Signature of Patient or authorized individual **Print** Patient's Name Date

(This person) _____ has my permission to receive my medical information.