PROLIANCE SURGEONS

PATIENT REGISTRATION

Patient Name ______________________________ Male ( ) Female ( )
Last First Middle Initial (Nickname)

Home Address ______________________________ Home Phone ( ) ______________
Street Apt. # Area Code

____
City State Zip

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Dependent ( )

Birthdate _______ / _______ / _______ Age __________ Social Security # ______________

Primary Care Physician ______________________ Home Phone ( ) ______________
Area Code

Are you consulting an attorney for this injury? Yes / No If yes, Name & Phone # ______________

Patient's Employer / School ______________________ Work Phone ( ) ______________
Area Code

Employment / School ______________________ Occupation ______________
Street Address

____
City State Zip

Parent / Spouse Name ______________ Employer ______________ Phone ______________

How were you recommended to us?

Referring Doctor ______________ Emergency Room ______________ Postcard / Mailing ______________

Friend / Family ______________ Phone Book ______________ Other: ______________

BILLING INFORMATION

Name of person responsible for bill ______________________________
Relationship Social Security #

Address (if not as above) ______________________________
City State Zip

Home Phone ______________ Employer ______________

Work Phone ______________ Address ______________

IN ORDER TO BILL YOUR INSURANCE, WE MUST HAVE A COPY OF YOUR CARD

PRIMARY INSURANCE

Ins. Co. Name ______________

Subscriber Name ______________

Date of Birth ______________

Group # ______________ ID# ______________

Subscriber's Employer ______________

Does your insurance carrier require a referral? Yes ( ) No ( )

SECONDARY INSURANCE

Ins. Co. Name ______________

Subscriber Name ______________

Date of Birth ______________

Group # ______________ ID# ______________

Subscriber's Employer ______________

Does your insurance carrier require a referral? Yes ( ) No ( )

EMERGENCY INFORMATION

Name of a local person
not living with you ______________________ Relationship ______________

Address ______________________ Telephone # ______________

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished me by any of the physicians of Proliance Surgeons, Inc. P.S. I authorize any holder of medical information about me to release to HCFA and it's agents or to my other insurance any information needed to determine these benefits. I authorize the treatment of the person named above and agree to pay for all fees and charges for such treatment, and I accept full financial responsibility for non-covered services.

______________________ ______________________
Signature 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#_____________

__Workers Compensation

__Department of Labor & 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 if 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: _______________

SEATTLE ORTHOPEDIC CENTER

PATIENT MEDICAL HISTORY

AME (Please Print) ______________________________ AGE __________

EX: M F HEIGHT __________ WEIGHT __________ HANDED: R L

AME OF FAMILY DOCTOR ______________________________

EDICATIONS: Please list medications along with dosages. [ ] None

____

____

____

EDICATION ALLERGIES: Please list all allergies to medications. [ ] None

____

____

REVIOUS SURGERIES: Please list all previous surgeries. [ ] None

____

____

____

AVE YOU EVER HAD ANY PROBLEMS WITH SURGERY OR ANESTHESIA?

] None [ ] Yes. Please Describe. ______________________________

____

____

O YOU SMOKE? [ ] No [ ] Yes. How Much? ______________________________

O YOU DRINK ALCOHOL? [ ] No [ ] Yes. How Much? ______________________________

O YOU HAVE NOW OR HAVE YOU OR A FAMILY MEMBER EVER HAD:

	Past Problem	Current Problem	Never	Family History		Past Problem	Current Problem	Never	Family History
nemia	[ ]	[ ]	[ ]	[ ]	Glaucoma	[ ]	[ ]	[ ]	[ ]
rthritis	[ ]	[ ]	[ ]	[ ]	Gout	[ ]	[ ]	[ ]	[ ]
sthma	[ ]	[ ]	[ ]	[ ]	Heart Problems	[ ]	[ ]	[ ]	[ ]
ad Teeth	[ ]	[ ]	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	[ ]	[ ]
ladder Infection	[ ]	[ ]	[ ]	[ ]	Kidney Disease	[ ]	[ ]	[ ]	[ ]
leeding Problems	[ ]	[ ]	[ ]	[ ]	Liver Disease	[ ]	[ ]	[ ]	[ ]
lood Clots	[ ]	[ ]	[ ]	[ ]	Psychiatric Treatment	[ ]	[ ]	[ ]	[ ]
ancer	[ ]	[ ]	[ ]	[ ]	Stomach Ulcers	[ ]	[ ]	[ ]	[ ]
epression	[ ]	[ ]	[ ]	[ ]	Stroke	[ ]	[ ]	[ ]	[ ]
iabetes	[ ]	[ ]	[ ]	[ ]	Thyroid Disorders	[ ]	[ ]	[ ]	[ ]
mphysema	[ ]	[ ]	[ ]	[ ]	Tuberculosis	[ ]	[ ]	[ ]	[ ]
pilepsy	[ ]	[ ]	[ ]	[ ]	Other Illnesses	[ ]	[ ]	[ ]	[ ]

____

RE YOU:

regnant [ ] No [ ] Yes

Taking Birth Control [ ] No [ ] Yes

resently Being Treated for Any Illness [ ] No [ ] Yes

ware of Any Change in Your General Health in the Past Year [ ] No [ ] Yes

ware of Any Recent Weight Change [ ] No [ ] Yes

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

ignature ______________________________ **Date** ______________

I.D. Initials ______________________________ **Date** ______________

SOC Seattle Orthopedic Center

a service of PROLIANCE SURGEONS®

2409 North 45th Street • Seattle, WA 98103 www.seattleorthopediccenter.com

RELEASE OF INFORMATION

Seattle Orthopedic Center
(206) 633-8100
Fax (206) 633-6107

Ambulatory Surgery Center
(206) 633-8100
Fax (206) 633-6073

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

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

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

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
Orthopedic & Fracture Surgery
Total Joint Replacement

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

J. Michael Watt, M.D.
Orthopedic & Sports Medicine
Knee & Shoulder Arthroscopy

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