PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE

BELLEVUE • ISSAQUAH • REDMOND

A Service of

PROLIANCE SURGEONS®

PATIENT INFORMATION

Name ______________________________________ Social Security # ____________________
Last First Middle

Ethnicity: ❑ Declined ❑ Hispanic ❑ Non-Hispanic ❑ Unknown

Race: ❑ African American ❑ American Indian, Alaska Native ❑ Asian ❑ Caucasian ❑ Declined ❑ Native Hawaiian, Pacific Islander ❑ Other

Preferred Language: ❑ English ❑ Spanish ❑ Other:___________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner ❑ Widowed

Birthdate_____________ Age ______ __ Male __ Female

Home Address ______________________________________ ____________________________
Street City State Zip

Home Phone ______________________ Cell Phone ______________________

Email address ________________________ Employer ______________ Occupation____________

Employer Address ________________________________ Work Phone ______________________

Spouse/Parent Name ____________________ Work Phone __________________________

Spouse/Parent Employer ______________________

PRIMARY CARE PHYSICIAN: ________________________ **REFERRED BY:**________________________

Reason for this visit: Illness____ Injury____ Job related injury____ Auto accident_____ Other _____

Date of injury or onset of problem______________ Part of body injured ________________ __ Right __ Left

How did this happen? ____

If you were hospitalized for this: Where ____________________ When_______________

Worker's Comp / Auto Insurance Carrier _____________________________ Claim #______________

Address______________________Claim Mgr Name & Number__________________Date of Injury/Accident______

Primary Insurance___________________ ID# ________________________ Group # ____________

Subscribers Name _______________ Subscriber's Date of Birth _______ Relationship to subscriber __ self __ spouse __ child

Claims Billing Address ______________________________ Phone ______________

Secondary Insurance___________________ ID#_________________________ Group #___________

Subscribers Name _______________ Subscriber's Date of Birth _______ Relationship to subscriber __ self __ spouse __ child

Claims Billing Address ______________________________ Phone ______________

In case of EMERGENCY Relative to contact (not living with patient) _____________________________

Relationship ______________________________ Phone _______________

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party ________________________ Address ______________________________

Relationship to patient ______________ Social Security # ______________________ Birthdate ____________

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and/or insurance company to release any information required for this claim.

Note: If the patient is under 18 years of age, the accompanying parent is responsible for all bills.

Signature ______________________________________ **Date** _________________

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Health History

This history form provides us with information to help us meet your healthcare needs. Please complete this form answering each question. ***This is a confidential part of your medical record and will be kept in this office.***

Patient Name: ________________________ **Birthdate**________________ **Date** _____________

What condition/body part(s) are you being seen for today? ______________________________________
____

Onset date:_____________________ Previous treatment for this condition? ❒ Yes ❒ No

Treatment given: ______________________________ Date treated: ____________________
____

Where treated: ____

Check all treatment(s) received for this condition:

Anti-inflammatories	___________	X-rays	___________	Hospitalization	___________
Pain medication	___________	MRI	___________	Casting/splint	___________
Muscle relaxant	___________	CT scan	___________	Physical therapy	___________
Injection	___________	Bone scan	___________	Fracture to put back in place	___________
Surgery & Date	___________	EMG	___________		

Allergies

❒ None Height __________ Weight __________

List all known allergies:

____
____
____

Current Medications

❒ None ❒ See attached list

List all known medications and dosage:

____
____
____
____
____
____

Past Medical History

Have you ever had:	No	Yes	Year
Anemia			
Angina			
Arthritis			
Asthma			
Bad teeth			
Bladder infection			
Bladder problems			
Blood clots			
Cancer			
Depression			
Diabetes			
Emphysema			
Epilepsy			

Have you ever had:	No	Yes	Year
Glaucoma			
Gout			
Heart attack			
Heart arrhythmia			
Hepatitis			
High blood pressure			
Kidney disease			
Liver disease			
Psychiatric treatment			
Stomach ulcers			
Stroke			
Thyroid disorders			
Tuberculosis			

Continued on Reverse

Social History

Please answer each of the following:

Occupation: ______________________________ How many years? ____________

	No	Yes	How Much
Caffeine:			
Drugs:			

	No	Yes	How Much
Tobacco:			
Alcohol:			

Family History

Is there a family history of arthritis, heart disease, stroke or cancer or any other systemic condition?

❒ No ❒ Unknown ❒ Yes (explain below)

Condition and relative:____

Previous Surgeries

❒ None List procedure and date performed:

____

____

____

____

____

____

Review of Systems

Check all conditions and symptoms that you currently have:

1 *General*	____ Fever	___ Chills	___ Weight loss	___ Weight gain
2 *Eyes*	____ Blurred vision	___ Double vision	___ Poor vision	___ Glasses
3 *Ears/nose/throat*	____ Ringing in ears	___ Sinus congestion	___ Hearing loss	___ Sore throat
4 *Heart*	____ Chest Pain	___ Irregular heart beat	___ Palpitations	___ Other
5 *Lungs*	____ Cough	___ Shortness of breath	___ Difficulty breathing	___ Other
6 *Intestinal*	____ Upset Stomach	___ Bloody stools	___ Constipation	___ Diarrhea
7 *Urinary*	____ Burning	___ Frequent urination	___ Incontinence	___ Other
8 *Musculoskeletal*	____ Joint pain	___ Muscle weakness	___ Joint stiffness	___ Other
9 *Skin*	____ Rashes	___ Sores	___ Masses	___ Scars
10 *Neurological*	____ Tremors	___ Numbness	___ Poor balance	___ Dizziness
11 *Psychiatric*	____ Depression	___ Mood swings	___ Anxiety	___ Other
12 *Endocrine*	____ Hair loss	___ Excessive thirst	___ Fatigue	___ Other
13 *Blood/Lymphatic*	____ Leg swelling	___ Bleeding tendency	___ Bruise easily	___ Other
14 *OB/GYN*	____ Pregnant	___ Birth control pills	___ Hormone therapy	___ Menopausal

Provider Comments ____

____

____ ❒ All other systems negative

Patient Signature: ____________________ Provider Signature: ____________________

Date: ____________________ Date: ____________________

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Authorization to Leave Personal Health Information By Alternate Means

Patient Name: ______________________________ **Date of Birth:**______________________

Patient Mailing Address:____

(Please check all that apply)

☐ May leave detailed message on voicemail at home # :____________________________

☐ May leave detailed message on voicemail at work # :____________________________

☐ May leave information with spouse (name):____________________________

☐ May leave information with other family member:____________________________

☐ May leave detailed message on cellular phone # :____________________________

☐ May leave detailed message at a different location # :____________________________

☐ May send detailed message by email to:____________________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

____ ____________________

Patient or legally authorized individual signature Date