ProOrtho
a division of PROLIANCE SURGEONS, INC., P.S.
ORTHOPEDICS & SPORTS MEDICINE
Personalized care. Optimal results.

Pt. Label

Patient Registration

Patient Name: _____ Gender: _____
Last First Middle Initial

Mailing Address: _____ Home Phone: _____
Street Unit #

City: _____ State: _____ Zip: _____ Day/Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Widow/er ☐ Divorced ☐ Dependent

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Unknown ☐ Prefer not to disclose ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Prefer not to disclose

Preferred Language: _____ Email: _____

Birthdate: ____/____/____ Age: _____ Social Security #: _____

Primary Care Physician: _____

Referred by Dr./Other: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Information About Your Condition

What part of the body are you being seen for today? _____ ☐ L ☐ R

Is this a result of a work or auto injury? ☐ Yes ☐ No If **Yes**, please complete the following:

Date of Injury: ____/____/____ Claim Number: _____

Workers' compensation billing address: _____
Street City State Zip

Claim Manager Name: _____ Phone: _____

Billing Information
(Complete if person responsible for bill is not the patient.)

Name of person responsible for bill: _____
D.O.B. Relationship Social Security #

Address (if not as above): _____
Street City State Zip

Phone: _____ Employer: _____

Primary Insurance

Insurance Company Name: _____

Subscriber Name: _____

Subscriber DOB: _____

Other Insurance

Insurance Company Name: _____

Subscriber Name: _____

Subscriber DOB: _____

I authorize my insurance benefits to be paid to ProOrtho Orthopedics & Sports Medicine and I understand I am financially responsible for any unpaid balance. I authorize the physician or insurance company to release any information required for this claim. ProOrtho may send you non-personally identified communication to assess your satisfaction with our services. You may opt out of such communication at any time.

_____ _____ _____
Patient or Guardian Signature Date Relationship to Patient (If other than self)

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AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name: _____ Date of Birth: _____
Last First Middle MM/DD/YYYY

May leave detailed message on:

Home Voicemail: (_____) _____ - _____

Work Voicemail: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Other: (_____) _____ - _____

Preferred number to be reached during business hours: ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Other**

May leave information with:

Spouse/Partner: (_____) _____ - _____ Name: _____

Other: (_____) _____ - _____ Name: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and 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.

Signature _____ Date _____
Patient or legally authorized individual

PROLIANCE SURGEONS®

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

_____ _____

Signature of Patient or Guardian Date Time

_____

Printed Name

Effective: April 14, 2003 (Revised: September 23, 2013)

PROLIANCE SURGEONS®

ProOrtho

Patient Financial Responsibilities

ProOrtho, a division of Proliance Surgeons, is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing ProOrtho.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

Surgery – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Office Visits – A $250.00 deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

Surgery – For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

Exclusions – The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $250.00 deposit that will be refunded after the claim has been opened.

Other Charges

No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We charge 5% interest accruing monthly on balances over 45 days old. We may assign an account to collections if balances are unpaid after 120 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with ProOrtho, or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

Patient Signature: _____ **Date:** _____

ProOrtho
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Patient Health History Form

Phone: (425) 823 - 4000 Fax: (425) 821 - 3550

Patient Label:

Male: ☐ Female: ☐ (Pregnant: No ☐ Yes ☐ Unsure ☐

Height: _____ Weight: _____

Office Use: BP:_____ HR:_____

Referring Physician: _____

Primary Care Physician: _____

What are you being seen for today? _____

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.

_____

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)			
10)			

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

ProOrtho Patient Health History Form- Page 2

Patient Label:

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)		

PAST MEDICAL HISTORY

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

ProOrtho Patient Health History Form- Page 3

Patient Label:

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

	Mother	Father	Son	Daughter	Brother	Sister	Other
Anesthesia Problems							
Arthritis							
Back Pain							
Cancer: _____							
Clotting Disorder							
COPD/Emphysema							
Diabetes							
Drug Addiction							
Alcohol Addiction							

	Mother	Father	Son	Daughter	Brother	Sister	Other
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_____

ProOrtho Patient Health History Form- Page 4

Patient Label:

REVIEW OF SYSTEMS

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

Constitution	Eyes	Gastrointestinal	Other
☐ Fever	☐ Blurred Vision	☐ Heartburn	☐ Easy Bruise/Bleed
☐ Chills	☐ Double Vision	☐ Nausea	☐ Environmental Allergies
☐ Weight Loss	☐ Sensitivity to Light	☐ Vomiting	☐ Other _____
☐ Malaise/Fatigue	☐ Eye Pain	☐ Abdominal Pain	
☐ Sweating	☐ Eye Discharge	☐ Diarrhea	**Neurological**
☐ Weakness	☐ Eye Redness	☐ Constipation	☐ Dizziness
☐ Other _____	☐ Other _____	☐ Blood in Stool	☐ Headaches
		☐ Melena	☐ Tingling
Skin	**Cardiovascular**	☐ Other _____	☐ Tremor
☐ Rash	☐ Chest Pain		☐ Sensory Change
☐ Itching	☐ Palpitations	**Genitourinary**	☐ Speech Change
☐ Other _____	☐ Shortness of Breath	☐ Painful Urination	☐ Focal Weakness
	☐ Leg Cramps	☐ Urgency of Urination	☐ Seizures
HENT	☐ Leg Swelling	☐ Frequency of Urination	☐ Loss of Consciousness
☐ Hearing Loss	☐ Sleep Apnea	☐ Blood in Urine	☐ Other _____
☐ Ringing in Ears	☐ Other _____	☐ Flank Pain	
☐ Ear Pain		☐ Other _____	**Mental Health**
☐ Ear Discharge	**Respiratory**		☐ Depression
☐ Nosebleeds	☐ Coughs	**Musculoskeletal**	☐ Suicidal Ideas
☐ Congestion	☐ Coughing up Blood	☐ Muscle Pain	☐ Substance Abuse
☐ Sinus Pain	☐ Sputum Production	☐ Neck Pain	☐ Hallucinations
☐ Stridor	☐ Shortness of Breath	☐ Back Pain	☐ Nervous/Anxious
☐ Sore Throat	☐ Wheezing	☐ Joint Pain	☐ Insomnia
☐ Excessive Thirst	☐ Other _____	☐ Falls	☐ Memory Loss
☐ Other _____		☐ Other _____	○ Other _____

◯ **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: _____