ProOrtho
a division of
PROLIANCE SURGEONS INC., P.S.

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Please see attached paperwork for your upcoming appointment with ProOrtho.

Your appointment is located at:

12911 120th Ave NE
Suite H210
Kirkland, WA 98034
(425)823-4000

Heading North in I-405 (From Bellevue)

- Take exit 20B (Totem Lake / 124th Street Exit).
- Follow the sign to Totem Lake Boulevard (the option furthest to the right).
- At the end of the off ramp, at the light, go straight ahead.
- This puts you onto 120th.
- Follow 120th up the hill, Evergreen Hospital will be directly on your right.
- Turn Left at 130th Lane. Evergreen Pharmacy will be directly on your left.
- Follow down the hill to the end of the complexes, making a left at the bottom of the hill.
- Building H is the Brick and Green building located at the back of the complex.

Heading South on I-405 (From Everett / Bothell)

- Take Exit 20 (124th Street Exit).
- At the end of the off-ramp, at the light, turn right onto 124th.
- At the next light turn right onto 116th. At this point you will be heading north parallel with the freeway.
- At 128th, turn right.
- At the second light, turn left onto 120th.
- At the next light, 130th Lane, turn left (at Evergreen Pharmacy).
- Follow down the hill to the end of the complexes, make a left at the bottom of the hill.

Please be sure to bring your photo id, insurance card, and copay if applicable.

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PATIENT REGISTRATION

Patient Name_____
Last First Middle Initial (Nickname)

Home Address_____
Street Apt. #

_____
City State Zip

Home Phone (**)** _____ **Cell Phone (** **)** _____
Area Code Area Code

Emergency Contact_____ **Emergency Phone (** **)** _____

Male ( ) Female ( ) Body part being evaluated_____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widow/er

Birth date: ___/___/_____ Age: _____ Social Security # _____

E-Mail _____

Race:_____ **Language:**_____ **Ethnicity:**_____

Primary Care Physician: _____ **Phone # (** **)**_____

Referred by (Dr./Patient/Friend): _____

Referred By Attorney?_____**Phone # (** **)**_____

Patient's Employer/School:_____ **Phone # (** **)** _____

BILLING INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Co. Name: _____	**Ins. Co. Name:**_____
Subscriber Name: _____	**Subscriber Name:** _____
Date of Birth: _____	**Date of Birth:** _____
Policy #:_____	**Policy #:**_____
Group #: _____	**Group #:** _____
Employer: _____	**Employer:** _____

Does your insurance carrier require a referral? ( ) Yes ( ) No
Is this a labor and industries claim? ( ) Yes ( ) No

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 EOC. I authorize any holder of medical information about me to release to HCFA and its agents or to my 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**

Turn Over →→

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®

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

Last Update: 2/11/2004

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PROLIANCE SURGEONS INC., P.S.

Date:_____

ORTHOPEDIC HISTORY FORM

Please take a few minutes to complete this form. By doing so you will help your physician to provide the best medical care possible. Thank you. (Please circle appropriate choices, when given inside parentheses.)

Name _____ **Age** _____ **Date of birth**_____

Any previous surgery at problem site? _____ Prev Surgery Date _____

Location of problem? _____ Onset date _____

If injury, describe briefly: _____

_____

INJURY/SYMPTOMS

Did you feel/hear a pop or tear?	Yes	No	Unsure
Did your joint pop out?	Yes	No	Unsure
Did you have weakness?	Yes	No	Unsure
Did you continue activity?	Yes	No	
Did it feel loose/unstable?	Yes	No	

PRIOR TREATMENT:

Did you see a physician ?	Yes	No	MD name:_____
Were X-rays taken?	Yes	No	
Medication prescribed?	Yes	No	Rx name:_____
Physical Therapy?	Yes	No	
Injection(s)?	Yes	No	

Other treatment? _____

SYMPTOMS/COMPLAINTS:

Pain: Location (front back top side inside outside)
Severity: rate 1-10 _____ (mild severe)
Frequency: (occasional intermittent constant)
Type (sharp aching throbbing burning)
Aggravated by: (lifting reaching walking running twisting pushing squatting kneeling stairs overhead use throwing)

Stiffness: (none occasional frequent)
Numbness/tingling? Yes No Where? _____
Swelling? (none occasional frequent constant) Intensity: (mild moderate severe)
Weakness: Yes No Where?_____
Grinding/Grating? (none occasional frequent) Nighttime pain? Yes No
Giving Way/Buckling? (none occasional frequent) Locking: (none occasional frequent)
Bowel/Bladder Incontinence? Yes No

PRESENT OVERALL FUNCTION (give percentage): _____
How far can you walk? _____ blocks _____ miles

Can you climb stairs ____Yes ____No ____ without assistance ____ with assistance

What is your present occupation? _____

Are you currently working? Yes No (if No) date last worked? _____

Patient Signature_____**Date**_____ **Doctor Signature**_____**Date**_____

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Patient Health History Form

12911 120th Avenue NE H-210, Kirkland, WA 98034
Phone: (425) 823 - 4000 Fax: (425) 821 - 3550

DEMOGRAPHICS

Name: _____

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

Primary Phone #: _____

Other Phone #: _____

Date of Visit: _____

Date of Birth: _____ Age Today: _____

Height: _____ Weight: _____

Office Use: BP: _____ HR: _____

Referring Physician: _____

Primary Care Physician: _____

Is this a work related injury? No ○ Yes ○

Have you filed a Worker's Compensation claim for your injury? No ○ Yes ○, what date: _____

Have you worked with a lawyer as a result of your injury? No ○ Yes ○

What are you being seen for today? _____

_____

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			

ProOrtho 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)		
7)		
8)		
9)		
10)		

Have you ever had a blood transfusion? O No O Yes, what date? _____

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? _____

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

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)			

ProOrtho 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 mark conditions in your immediate family:

○ Anesthesia (life threatening problems)
○ Arthritis- "wear and tear"
○ Back pain
○ Blood clots/ bleeding tendencies
○ Cancer: (types:_____)
○ COPD/ Emphysema
○ Depression
○ High blood pressure (hypertension)
○ Diabetes
○ Drug and alcohol addiction
○ Heart disease
○ Malignant hyperthermia
○ Osteoporosis/ osteopenia
○ Rheumatoid arthritis
○ Sleep apnea
○ Stroke
○ 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

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: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Proliance Surgeons, Inc., P.S. respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Laws protect the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment plans, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care. NOTE – You may request that we not share information with your health plan provided that: (i) the disclosure is for purposes of payment or health care operations and is not otherwise required by law, and (ii) the health information pertains solely to health care items or services for which you, or another person on your behalf (other than a health plan) has paid in full.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you during negotiations with your health insurance carrier or to inform you of changes with our relationship to your health insurance carrier.
- Under certain circumstances, we may use and disclose your information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose your information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who

may be included in their research project or for other similar purposes, as long as they do not remove, take, or copy your information.
- We may use or disclose your health information to provide legally required notices of unauthorized access to or disclosure of your health information.
- We may use and disclose your information to conduct or arrange for services, including:
- medical quality review by your health plan;
- accounting, legal, risk management, and insurance services, and
- audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.
- Request and receive from us a copy of this or the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- You have the right to request to be given or have transmitted to another individual or entity, an electronic copy of your medical record, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request, however, if it is not readily producible by us, we will provide it in our standard format (fees my apply).
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- You have the right to request a restriction or limitation on the disclosure of your health information for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone involved in your care or involved in the payment of your care. Your request must be made in writing with specific instructions. If we agree to this restriction, we may violate the request only for emergency treatment. You may not request that we restrict the disclosure of your health information for treatment purposes.

For help with these rights during normal business hours, please contact the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our Responsibilities

We are required to:
- Keep your protected health information private;
- Give you this Notice, and
- Follow the terms of this Notice and state and federal laws.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.

You have the right to object to this use or disclosure of your information. If you object, we will disclose it to your family member or friends.

We may use and disclose your protected health information without your authorization as follows:

With Medical Researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
  - to prevent or reduce a serious, immediate threat to the health or safety of a person, or the public, and
  - to public health or legal authorities;
  - to protect public health and safety
  - to prevent or control disease, injury, or disability
  - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.
- Uses and disclosure of psychotherapy notes or HIV status will only be made with your written authorization or as allowed by law.
- Uses and disclosures of Protected Health Information for marketing purposes; and disclosures that constitute a sale of your Protected Health Information will be made only with your written authorization.

For Additional Information, For Assistance or To Complain

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.proliancesurgeons.com.
- If you have questions, want more information, or want to report a problem about the handling of your protected health information, please contact the administrator of the location at which you have been treated. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also contact the administrator at any of our practice/health care facilities or Proliance Surgeon's privacy office at (206)838-2590. You may also contact the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the last page, in the lower left-hand corner.

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