New Patient Demographics

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Patient's Name:____ DOB: ______________
Last *First* *MI* *(MM/DD/YYYY)*

Parent/Guardian 1*(if applicable)*: _____________________ Parent/Guardian 2: ____________________

Marital Status: **M** **S** **D** **W** • Spouse's Name: _____________________ DOB: _____________

Mailing Address:____

Cell: ___________________ Home Phone: ____________________ Work: __________________

Email Address: ____________________________ Appt. Reminders: **Call** **Text** **Email**

Emergency Contact: ________________ Phone: __________________ Relation: _______________

Primary Care Provider:_________________________ • Referred By: _________________________

Primary Insurance: _________________________
Insurance ID#: ____________________________
Insurance Group#: _________________________
Policy Holder Name:________________________
Policy Holder DOB: ________________________

Secondary Insurance: _______________________
Insurance ID#: ____________________________
Insurance Group#: _________________________
Policy Holder Name:________________________
Policy Holder DOB: ________________________

Tertiary Insurance: _________________________
Insurance ID#: ____________________________
Insurance Group#: _________________________
Policy Holder Name:________________________
Policy Holder DOB: ________________________

Worker Comp/Auto Ins: ______________________
Claim #: _________________________________
Date of Injury/Accident: _____________________
Adjuster Name: ____________________________
Adjuster Phone #:___________________________

I authorize PPO to release my Protected Health Information to the family or friend's listed below.

1.______________________________DOB:_________ Relationship:___________________

2.______________________________DOB:_________ Relationship:___________________

____
Patient/Parent/Guardian Signature **Today's Date**

Please initial here: _________ if you DO want us to send a copy of our visit to your personal Physician/Provider.

Orthopedic History Questionnaire

Name:____________________________________ **Date of Birth:**______________ **Age:** _________ **Sex:** ☐ Male ☐ Female

Hand Dominance: ☐ Right ☐ Left **Referring Physician:**____________________ **Primary Care Physician:** _________________

When did your symptoms begin: ______________________ Is this work related? ☐ Yes ☐ No Pain Contract: ☐ Yes ☐ No

Describe your injury/symptoms: ____

____

Check all that apply:	Never	Occasionally	Constant
Pain at rest	☐	☐	☐
Pain with activities	☐	☐	☐
Loss of motion	☐	☐	☐
Night pain	☐	☐	☐
Numbness/tingling	☐	☐	☐
Popping/clicking	☐	☐	☐
Grinding	☐	☐	☐
Instability/looseness	☐	☐	☐
Morning stiffness	☐	☐	☐
Giving way	☐	☐	☐
Swelling	☐	☐	☐

Do you have difficulty with:	Never	Occasionally	Constant
Personal care	☐	☐	☐
Work activities	☐	☐	☐
Lifting	☐	☐	☐
Reaching overhead	☐	☐	☐
Climbing stairs	☐	☐	☐
Weather changes	☐	☐	☐
Kneeling	☐	☐	☐
Sleeping	☐	☐	☐

Pain Scale: 1 2 3 4 5 6 7 8 9 10
(Please circle one)

What makes it worse? ☐ Activity ☐ Overuse ☐ Walking ☐ Lifting ☐ Sitting ☐ Sleeping ☐ Other_________________

What makes it better? ☐ Ice ☐ Rest ☐ Medication ☐ Other____

Current Medications	**Dose**	**Current Allergies**	**Reaction**

Past Medical History:

☐ Anemia ☐ Arthritis ☐ Bleeding Disorders/clots ☐ Cancer ________________________ ☐ Depression ☐ Diabetes

☐ Heart Disease ☐ Hepatitis ☐ A ☐ B ☐ C ☐ High blood pressure ☐ Kidney/Liver Disease ☐ Lung Disease/Difficulty Breathing

☐ MRSA ☐ Thyroid Disease ☐ Trauma/Broken Bones ☐ Tuberculosis ☐ Ulcer/Stomach Problems ☐ Other _________________

Prior Hospitalization? ____

Previous Surgeries *(Surgery & Year)* ____

____

Family Medical History:

☐ Alcoholism ☐ Cancer ___________________________ ☐ Chronic Pain ☐ Diabetes ☐ Disability ☐ Depression

☐ Heart Disease ☐ High blood pressure ☐ Migraine ☐ Stroke ☐ Substance Abuse ☐ Other ____________________________

Social History:

Occupation: ___________________________________ Currently Working? ☐ Yes ☐ No

Tobacco? ☐ Yes ☐ No ☐ Former Smoker How much?_________packs/day How long?________years

Drink Alcohol? ☐ Yes ☐ No How much? How long? ________years

Caffeine? ☐ Yes ☐ No How much?_______________ How long?________years

Illegal Drug Use? ☐ Yes ☐ No How much? ________________ How long?________years

Marijuana Use? ☐ Yes ☐ No How much? ________________ How long?________years

Review of Current Symptoms

Are you currently having or have had problems with your (check boxes that apply)

Constitutional	☐ Fatigue ☐ Weight Gain ☐ Weight Loss ☐ Headache ☐ Other______________________
Eyes	☐ Blurred Vision ☐ Glasses/Contacts ☐ Other____________________________________
Ears, Nose, Throat	☐ Congestion ☐ Hearing Loss ☐ Jaw Discomfort ☐ Other_____________________________
Lungs, Breathing	☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ Other_____________________________
Heart	☐ Chest Pain ☐ Irregular Heartbeat ☐ Heart Murmurs ☐ Other_______________________________
Gastrointestinal	☐ Nausea ☐ Vomiting ☐ Stomach Aches ☐ Constipation ☐ Diarrhea ☐ Other _________________
Bladder	☐ Incontinence ☐ Urinary Tract Infection ☐ Difficulty Urinating ☐ Other______________
Endocrine	☐ Diabetes ☐ Thyroid problems ☐ Delays in growth ☐ Other______________________
Musculoskeletal	☐ Joint pain ☐ Leg Pain ☐ History of Broken Bones ☐ Other________
Bleeding Problems	☐ Anemia ☐ Prolonged Bleeding after Cut/Injury ☐ Other_____________________________
Neurological	☐ Numbness/tingling ☐ Dizziness ☐ Headaches ☐ Frequent Falls ☐ Other_____________
Integumentary	☐ Rashes ☐ Skin Disorders ☐ Connective Tissue Disorders ☐ Other______________________
Psychiatric	☐ Change of mood behavior ☐ Change in sleep patterns ☐ Other______________________
Immunologic/Allergic	☐ Asthma ☐ Communicable Diseases ☐ Chronic Rashes ☐ Hay Fever ☐ Other___________________
Gynecologic	Pregnant? ☐ Yes ☐ No ☐ Unsure Regular Menstrual Periods? ☐ Yes ☐ No

Any additional comments or information that you feel is important regarding your current medical condition:

____

____

____

____

____

____

____

I believe that the information provided above is accurate and complete: __________________________________ ______________

Patient Signature Date

Thank you for taking the time to help us better care for you!

OFFICIAL USE ONLY ☐ Scanned

Reviewed by: ___________________________________

Height: ___________ BP: __________ /__________

Weight: ___________ HR: _________ Temp: ______

Financial Policy

We are in-Network providers with Blue Cross Blue Shield, EBMS, CIGNA, Medicare, Medicaid/Denali Kid Care, Tricare, VA, Aetna, and MODA.

- As a courtesy to the patient we will check your eligibility and benefits before your appointment and bill your insurance. Your co-pay is due at time of service. You will be billed for any amount not covered by your plan in addition to your deductible, co-pay, and co-insurance amounts not collected at the time of service. If proof of insurance/eligibility cannot be provided, your account will be transferred to self-pay.
- We only accept Worker's Compensation claims that were filed with the Alaska Department of Labor. Your claim must be open and billable. You must provide your carriers information including claim number and date of injury. Please note we do **NOT** accept Federal or Out of State Workers' Compensation.
- A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. ***YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM.*** If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt.
- As a courtesy to our patients we offer payment plans for qualifying balances. Payment plans are based on a maximum number of months from the date services are rendered. All payments are applied toward your oldest date of service.
- If you are not in communication with our office concerning your outstanding balance your account could be sent to an outside collection agency.

- **I have read, understand, and agree to this financial policy.**
- **I understand that I am ultimately responsible for my balances, not my insurance carrier.**
- **I authorize PPO, LLC to release medical information to my insurance company when requested for payment.**
- **I understand that my signature authorizes benefits to be paid directly to PPO, LLC**
- **I understand that should this debt become delinquent the balances may be referred to a collection agency.**
- **I will be held responsible for all fees associated with the collection of my debt.**

BY SIGNING BELOW, I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT.

____________________________________ ________________
Printed Name of Patient ***Date of Birth***

____________________________________ ________________
Signature of Patient/Legal Representative ***Date***

PIONEER PEAK
ORTHOPEDIC SURGERY

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Acknowledgement & Receipt for

NOTICE OF PRIVACY PRACTICES

We are required by law to provide you with a copy of our Notice of Privacy Practices.

By signing below, you are acknowledging that you have been provided with a copy of our notice to *(keep or to view)* and that you have been given an opportunity to view it.

____ _______________________

Patient's Printed Name Date

____ _______________________

Patient/Legal Guardian's Signature Date