Pacific Rim Orthopaedic Surgeons-2979 Squalicum Pkwy, Ste 203, Bellingham 98225

Phone: 360-733-7670 or Fax: 360-647-1901

New Patient Packet

All forms must be completed and signed. Please print legibly.

Provider Seen Today: _____ Date: _____

Legal Name: Last _____ First _____ M.I. _____

Age: _____ DOB: _____ Soc Sec# _____ Sex: Marital Status: M S D W

If Patient is a minor, name of parent present: _____

Mailing Address: _____ City, State: _____ Zip: _____

Street Address: _____ City, State: _____ Zip: _____

Home Ph# _____ Cell Ph# Email: _____

Occupation: _____ Employer: _____ Ph# _____

Patient primary language, if not English: _____

Emergency Contact: _____ Phone # _____ Relationship: _____

Other Family Members Seen Here: _____

PCP: _____ Consult Requested by: _____

Insurance Information

Primary Ins. _____ Subscriber's Name: _____ DOB: _____

Subscriber ID# _____ Group# _____ Co-Payment: $ _____

Secondary Ins. _____ Subscriber's Name: _____ DOB: _____

Subscriber ID# _____ Group # _____ Co-Payment: $ _____

Work related injury? Yes / No Have you filed a claim? Yes / No Date of injury: _____

Claim Number: _____ Part of body injured: _____ (Circle one) Right / Left

Employer: _____ Contact: _____ Phone # _____

Auto Accident Injury? Yes / No ** **If auto accident injury, please ask Receptionist for Auto Accident Report****

I hereby authorize Pacific Rim Orthopedic Surgeon LLC to release to my insurance company any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to the providers as Pacific Rim Orthopedic Surgeons, LLC. I understand my insurance will be billed as a courtesy and any unpaid charges for myself or my minor child will be my responsibility. I further understand that this clause shall not be amended orally. I agree to pay any interest or collection fees that may be related to this account.

Responsible Party Signature: _____ Date: _____

CURRENT MEDICATIONS & ALLERGIES

In our efforts to improve patient care and safety, it is required that you complete this list with any current medications you are taking including the dosage, how often those medications are taken and the reason for taking them. Please include any known allergies to medications, latex, iodine, food, or metals.

Patient's Name: **Date of Birth**:

Primary Care Physician:

I) CURRENT MEDICATIONS:

Name of Medication	Dosage	How often	Reason

II) OVER THE COUNTER MEDICATIONS: (Including herbal and dietary supplements)

Name of Medication	Dosage	How Often	Reason

III) ALLERGIES:

_____

IV) Are you currently on a pain management or narcotic management contract with any provider (i.e. PCP, pain management specialist, etc.)? Yes / No

Patient's Signature: _____

Date: _____

Pharmacy Name:_____

Pharmacy Phone #:_____

Pharmacy Fax #:_____

Updated on (date): _____ MA Initials _____

PATIENT ACKNOWLEDGEMENT & RELEASE OF INFORMATION

Copies of these following policies are not mailed. Please review them on our website under the Patient Portal & Forms tab:
www.pacificrimorthopedic.com
Copies may also be obtained at the Reception Desk.

___ I acknowledge that I have reviewed the **PROS Financial Policy**. I have read, understand, and agree to the provisions of the policy.

___ I acknowledge that I have reviewed the **PROS Scheduling, Appt Timeliness, Patient Discharge Policy**. I have read, understand, and agree to the provisions of the policy.

___ I acknowledge that I have reviewed the **PROS Notice of Privacy Practices**. I have read, understand, and agree to the provisions of the policy.

___ I understand that I have the right to refuse any treatment.

___ I understand that it is my responsibility to understand my insurance plan benefits and verify my eligibility.

___ I understand that it is my responsibility to understand the risks and benefits of each procedure prior to it being rendered.

___ I understand that I have the right to obtain a second opinion.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ___Leave message with detailed information ___Leave message with call back number only

Cell Phone: ___Leave message with detailed information ___Leave message with call back number only

Work Telephone: ___Leave message with detailed information ___Leave message with call back number only

Written Communication

___ OK to mail to Home address ___ OK to mail to Work address

___ OK to fax to this number (____) ____ - _____ ___ OK to send information to Electronic Health Exchange

___ OK to Email. Email Address _____

I consent to allow secure release of information by phone or Electronic Health Record to:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____ **Date** _____

Patient Signature

_____ **Date** _____

Parent/Legal Guardian Signature