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

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

New Patient Packet for MINOR patient

All forms must be completed and signed. Please print legibly. Bring insurance card(s) and photo ID to visit.

Provider Seen Today: _____ Date: _____

MINOR PATIENT'S INFORMATION:

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

Age: _____ DOB: _____ Soc Sec # _____ Sex:

Mailing Address: _____

Mobile Phone: _____

Home Phone: _____ Other Phone: _____

Primary Care Physician: _____ Referred by: _____

Patient primary language, if not English: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____ **Name of Adult or Caretaker present:** _____

GUARANTOR'S INFORMATION:

Guarantor on Account: _____ Guarantor Account#: _____ DOB:

Mailing Address: _____ City, State, Zip:

Street Address: _____ City, State, Zip:

Email: _____

Mobile Phone: _____ Home Phone : _____ Other Phone: _____

Occupation: _____ Employer Name: _____

Primary language, if not English: _____

INSURANCE INFORMATION (POLICY HOLDER'S 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 PLLC 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: _____

OPTIONAL

Advanced Consent to Treat an Unaccompanied Minor Child

Please complete this form if your child will be coming to any clinic visits without a parent or legal guardian. This agreement will stay in effect for one year from the date of signature below unless revoked in writing by a parent or legal guardian.

_____ _____ _____

Printed Name of Minor Child | Account # | Date of Birth

I approve and give consent for my child, listed above, to attend visits alone for routine care and treatment for which my approval has been previously given. I know that I am responsible for all health care fees incurred by my child during these visits. I understand that a parent or legal guardian will be required to attend any visit during which consent for a procedure or surgery is needed.

_____

Printed Name of Parent/Legal Guardian 1 | Signature of Parent/Legal Guardian 1 | Date

☐ Primary Custody ☐ Shared Custody ☐ Sole Custody ☐ Can schedule & attend appointments

_____

Phone Number of Parent/Legal Guardian 1

_____

Printed Name of Parent/Legal Guardian 2 | Signature of Parent/Legal Guardian 2 | Date

☐ Primary Custody ☐ Shared Custody ☐ Sole Custody ☐ Can schedule & attend appointments

_____

Phone Number of Parent/Legal Guardian 2

Other co-parents or guardians who can schedule and attend appointments:

_____ _____

Printed Name of co-parent/guardian 3 | Printed Name of co-parent/guardian 4

For Foster Care:

I approve and give consent for the minor child, listed above, to go alone to visits for established routine care and treatment for which my approval has been given. Financial duty for health care fees owed during these visits is outlined in the foster care records.

_____

Printed Name of Court Chosen Case Manager | Signature of Case Manager

_____

Date of Signature | Phone Number

CURRENT MEDICATIONS & ALLERGIES

In our efforts to improve patient care and safety, it is IMPORTANT AND REQUIRED that you complete this list with any current medications the patient is 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: _____ Pharmacy Name:_____

Date: _____ 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(s) (check all that apply):

Appointment Reminders to (select 1)**:** ☐ Cell Phone (text) ☐ Cell Phone (call) ☐ Home Phone (call)

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 onl

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

Written Communication

___ OK to mail to Home address

___ OK to E-mail. E-mail Address _____

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

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____**DOB:**_____ **Date** _____

Patient Name (please print legibly)

_____ **Date** _____

Parent/Legal Guardian Name (please print legibly)