

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. Bring insurance card(s) and photo ID to visit.

Provider Seen Today: _____ Date: _____

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

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

Name & Relationship of Caretaker present: _____

Guarantor on Account: _____ Guarantor Account#: _____

Mailing Address: _____ City, State, Zip: _____

Street Address: _____ City, State, Zip: _____

Email: _____

Cell Phone# _____ Home Phone: _____ Other Phone: _____

Occupation: _____ Employer: _____ Ph# _____

Ethnicity: Not Hispanic or Latino Hispanic/Latino

Race: White American Indian/Alaska Native Black/African American Asian Other: _____

Patient primary language, if not English: _____ Interpreter Needed? Yes / No

Emergency Contact: _____ Phone # _____ Relationship: _____

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 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, PLLC. 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: _____

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 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 E-mail. E-mail Address _____

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

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____ **Date** _____

Patient Name (please print legibly) DOB: _____

_____ **Date** _____

Parent/Legal Guardian Name (please print legibly)