Proliance
Orthopaedics & Sports Medicine
BELLEVUE | ISSAQUAH | REDMOND

Patient Information

Name _____ Social Security # _____
First Last Middle

Ethnicity: ❑ Declined ❑ Hispanic ❑ Non-Hispanic ❑ Unknown

Race: ❑ African American ❑ American Indian, Alaska Native ❑ Asian ❑ Caucasian ❑ Declined ❑ Native Hawaiian, Pacific Islander ❑ Other

Preferred Language: ❑ English ❑ Spanish ❑ Other:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner ❑ Widowed

Birthdate_____ Age _____ ❑ Male ❑ Female

Home Address _____
Street City State Zip

Home Phone _____ Email address _____

Employer Address _____ Work Phone _____

Spouse/Parent Name _____ Work Phone _____

Spouse/Parent Employer _____

PRIMARY CARE PHYSICIAN:_____ **REFERRED BY:** _____

Reason for this visit: ❑ Illness ❑ Injury ❑ Job related injury ❑ Auto accident ❑ Other

Date of injury or onset of problem_____ Part of body injured _____ ❑ Right ❑ Left

How did this happen? _____

If you were hospitalized for this: Where _____ When_____

Worker's Comp / Auto Insurance Carrier _____ Claim #_____

Address_____ Claim Mgr Name & Number_____

Date of Injury/Accident_____

Primary Insurance_____ ID# _____ Group # _____

Subscribers Name_____ Subscriber's Date of Birth_____

Relationship to subscriber ❑ self ❑ spouse ❑ child

Claims Billing Address _____ Phone _____

Secondary Insurance_____ ID# _____ Group # _____

Subscribers Name_____ Subscriber's Date of Birth_____

Relationship to subscriber ❑ self ❑ spouse ❑ child

Claims Billing Address _____ Phone _____

IN CASE OF EMERGENCY Relative to contact _____

Relationship _____ Phone _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient _____ Social Security # _____ Birthdate _____

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and/or insurance company to release any information required for this claim.
Note: If the patient is under 18 years of age, the accompanying parent is responsible for all bills.

Signature _____ Date _____

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Health History

This history form provides us with information to help us meet your healthcare needs. Please complete this form answering each question. This is a confidential part of your medical record and will be kept in this office.

Patient Name: _____ **Birthdate**_____ **Date** _____

What condition/body part(s) are you being seen for today?

_____

Onset date: _____ Previous treatment for this condition? ❑ Yes ❑ No

Treatment given: _____

Date treated: _____ Where treated: _____

Check all treatment(s) received for this condition:

❑ Anti-inflammatories _____
❑ Pain medication _____
❑ Muscle relaxant _____
❑ Injection _____
❑ Surgery & Date _____
❑ X-rays _____
❑ MRI _____
❑ CT scan _____
❑ Bone scan _____
❑ EMG _____
❑ Hospitalization _____
❑ Casting/splint _____
❑ Physical therapy _____
❑ Fracture to put back in place _____

Height _____ Weight _____

Allergies ❑ None

List all known allergies:

_____

_____

Current Medications ❑ None ❑ See attached list

List all known medications and dosage:

_____

_____

_____

Past Medical History

Have you ever had:	No	Yes	Year
Anemia	❑	❑	
Angina	❑	❑	
Arthritis	❑	❑	
Asthma	❑	❑	
Bad teeth	❑	❑	
Bladder infection	❑	❑	
Bladder problems	❑	❑	
Blood clots	❑	❑	
Cancer	❑	❑	
Depression	❑	❑	
Diabetes	❑	❑	
Emphysema	❑	❑	
Epilepsy	❑	❑	

Have you ever had:	No	Yes	Year
Glaucoma	❑	❑	
Gout	❑	❑	
Heart attack	❑	❑	
Heart arrhythmia	❑	❑	
Hepatitis	❑	❑	
High blood pressure	❑	❑	
Kidney disease	◪	❑	
Liver disease	❑	❑	
Psychiatric treatment	❑	❑	
Stomach ulcers	❑	❑	
Stroke	❑	❑	
Thyroid disorders	❑	❑	
Tuberculosis	❑	❑	

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Social History

Occupation: _____ How many years? _____

	No	Yes	How Much
Caffeine	❑	❑	
Drugs	❑	❑	
Tobacco	❑	❑	
Alcohol	❑	❑	

Family History

Is there a family history of arthritis, heart disease, stroke or cancer or any other systemic condition?

❑ No ❑ Unknown ❑ Yes (explain below)

Condition and relative:

_____

_____

Previous Surgeries

❑ None List procedure and date performed:

_____

_____

_____

_____

Review of Systems

1 General	❑ Fever	❑ Chills	❑ Weight loss	❑ Weight gain
2 Eyes	❑ Blurred vision	❑ Double Vision	❑ Poor vision	❑ Glasses
3 Ears/nose/throat	❑ Ringing in ears	❑ Sinus Congestion	❑ Hearing loss	❑ Sore throat
4 Heart	❑ Chest Pain	❑ Irregular heart beat	❑ Palpitations	❑ Other
5 Lungs	❑ Cough	❑ Shortness of breath	❑ Difficulty breathing	❑ Other
6 Intestinal	❑ Upset Stomach	❑ Bloody stools	❑ Constipation	❑ Diarrhea
7 Urinary	❑ Burning	❑ Frequent urination	❑ Incontinence	❑ Other
8 Musculoskeletal	❑ Joint Pain	❑ Muscle weakness	❑ Joint stiffness	❑ Other
9 Skin	❑ Rashes	☑ Sores	❑ Masses	❑ Scars
10 Neurological	❑ Tremors	❑ Numbness	❑ Poor balance	❑ Dizziness
11 Psychiatric	❑ Depression	❑ Mood swings	☑ Anxiety	❑ Other
12 Endocrine	❑ Hair loss	❑ Excessive thirst	❑ Fatigue	❑ Other
13 Blood/Lymphatic	❑ Leg swelling	❑ Bleeding tendency	❑ Bruise easily	❑ Other
14 OB/GYN	❑ Pregnant	❑ Birth control pills	❑ Hormone therapy	❑ Menopausal

Provider Comments:

_____

_____ ❑ All other systems negative

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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Authorization to Leave Personal Health Information by Alternate Means

Patient Name: _____ **Birthdate**_____

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: _____