Providence SWEDISH

Orrthopedics

Pt. Label

Patient Registration

Patient Name: _____ DOB: _____ Gender: _____
Last First Middle Initial

Mailing Address: _____ Home Phone: _____
Street Unit #

City: _____ State: _____ Zip: _____ Day/Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Widow/er ☐ Divorced ☐ Dependent

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Unknown ☐ Prefer not to disclose ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Prefer not to disclose

Preferred Language: _____ Email: _____

Social Security #: _____

Primary Care Physician: _____

Referred by Dr./Other: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Information About Your Condition

What part of the body are you being seen for today? _____ ☐ L ☐ R

Is this a result of a work or auto injury? ☐ Yes ☐ No If **Yes**, please complete the following:

Date of Injury: _____ / _____ / _____ Claim Number: _____

Workers' compensation billing address: _____
Street City State Zip

Claim Manager Name: _____ Phone: _____

Billing Information
(Complete if person responsible for bill is not the patient.)

Name of person responsible for bill: _____
D.O.B. Relationship Social Security #

Address (if not as above): _____
Street City State Zip

Phone: _____ Employer: _____

Primary Insurance

Insurance Company Name: _____

Subscriber Name: _____

Subscriber DOB: _____

Other Insurance

Insurance Company Name: _____

Subscriber Name: _____

Subscriber DOB: _____

I authorize my insurance benefits to be paid to ProOrtho Orthopedics & Sports Medicine and I understand I am financially responsible for any unpaid balance. I authorize the physician or insurance company to release any information required for this claim. ProOrtho may send you non-personally identified communication to assess your satisfaction with our services. You may opt out of such communication at any time.

_____ _____ _____
Patient or Guardian Signature Date Relationship to Patient (If other than self)

Providence SWEDISH

Orthopedics

Health History

This history form provides us with information to help us meet your healthcare needs. Please complete this form answering each question.

Patient Name:_____ **Birthdate:**____/____/____ **Date:**_____

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_____

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

Current Medications

❒ None ❒ See attached list

List all known medications and dosage:

Preferred Pharmacy_____

Allergies

❒ None Height_____ Weight_____

List all known allergies:

Do you get shortness of breath climbing more than a flight of stairs? ❒ Yes ❒ No

Have you or any relatives had problems with anesthesia? ❒ Yes ❒ No

If yes, explain:_____

Do you see a cardiologist? ❒ Yes ❒ No If yes, name of doctor:_____

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			
Glaucoma			

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

Social Hstory

Please answer each of the following:

Occupation: _____ How many years? _____

	No	Yes	How Much
Caffeine:			
Drugs:			

	No	Yes	How Much
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

Check all conditions and symptoms that you currently have:

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*	___ Burining	___ 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: _____ Provider Signature: _____

Date: _____ Date: _____

Providence SWEDISH Orthopedics

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name: _____ Date of Birth: _____
Last First Middle MM/DD/YYYY

May leave detailed message on:

Home Voicemail: (_____) _____ - _____

Work Voicemail: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Other: (_____) _____ - _____

Preferred number to be reached during business hours: ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Other**

May leave information with:

Spouse/Partner: (_____) _____ - _____ Name: _____

Other: (_____) _____ - _____ Name: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and 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.

Signature _____ Date _____
Patient or legally authorized individual