Hand Surgery of Oregon - CONFIDENTIAL MEDICAL INFORMATION Today's Date: ___/___/____

Legal Name _____ Birthdate: ___/___/____
Last First MI Age _____

Please Circle:

1. Problem is on the: Right Left Both sides **I am: Right Left Handed**
2. Problem is at: elbow, forearm, wrist, finger (index, long, ring, small) thumb
3. Problem began on: _____ in a *sudden* or *slow* manner
4. Problem was a traumatic injury? Yes No Type of Injury: _____
5. Problem has: remained the same, worsened, improved
6. Problem is: occasional, intermittent, frequent, constant, 24hrs per day, daily
7. Please circle all that apply in describing the problem you experience:
   a. Pain: At rest minimal 1 2 3 4 5 6 7 8 9 10 severe
      With light use minimal 1 2 3 4 5 6 7 8 9 10 severe
      With heavy use minimal 1 2 3 4 5 6 7 8 9 10 severe
   b. Describe the type of pain: _____
   c. What makes the problem worse? _____
   d. What helps relieve the problem? Ice, heat, rest, activity, therapy, splint, medicine _____
   e. What do you experience? Feeling of swelling, visible swelling, popping, locking up, grinding, catching, aching, stiffness, soreness, fatigue, burning, pressure
8. Do you experience numbness, tingling, or decreased feeling?
   a. Thumb, index, long, ring, small, hand, wrist, forearm
   b. Is this numbness worse at night, driving, reading, with vibration?

9. LIST ALL MEDICATIONS YOU CURRENTLY TAKE FOR ANY MEDICAL CONDITION:

   _____
   _____
   _____

10. Allergies to medications (with type of reaction) _____
    _____

11. PRIOR OPERATIONS on ANY Body Part (Not just the hand) _____
    _____
    _____

12. Prior Major illnesses _____
    _____

13. Habits : Smoke: No Quit smoking in _____ (Congratulations!)
    Yes # Packs per day _____ For how many years? _____
    Alcohol consumption: _____ drinks per day, week, month, or year

14. Employer _____ Job Title _____
    Number of years working this type of job _____ Years with this employer _____

Hand Surgery of Oregon - CONFIDENTIAL MEDICAL INFORMATION (page 2 of 2) Today's Date: ___/___/____

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15. Recreational activities and hobbies (esp. what you enjoy doing that is more difficult now)

_____

_____

16. **Please circle** any problems you HAVE OR HAVE HAD in the past with your health:

Eyes, ears, nose, throat, neck, lungs, breathing, asthma, heart, chest pains, heart attack, stomach, liver, kidney, bowels, blood in the bowels, bladder, urination, urination at night, blood in urine, joint problems – neck, shoulders, elbows, wrists, fingers, hips, knees, ankles, feet, blood system, blood vessels, thyroid, headaches, seizures, swollen joints, childhood diseases like rheumatic fever, cancer, diabetes, tuberculosis, hepatitis, nervous breakdown, jaundice, blood clots, stroke, high blood pressure.
Please explain any:

_____

_____

17. Family History (circle all that apply): Carpal Tunnel, Tendon or nerve problems, Arthritis, Cancer
Other: _____

18. HEIGHT _____ WEIGHT _____ BOTH MUST BE COMPLETED

19. Have you seen Dr. Wilson previously for any reason? No Yes when? _____

20. Workers Compensation Information (Circle HERE if not applicable)
    a. Is this a work-related problem in your opinion? Yes No Why? _____
    _____
    b. Have you filed a form 801? Yes No
    c. What was your occupation at the time of injury? _____
    d. Do you still work for the same employer? _____
    e. Do you still perform the same job? _____
    f. Are you presently working? Yes No How long have you been off work? _____

21. What other physicians have you seen for this condition? _____
_____

22. Please check all of the tests which you have had performed for this condition:

	Yes	No	When	Where
Bone Scan	[ ]	[ ]	_____	
MRI	[ ]	[ ]	_____	
X Rays	[ ]	[ ]	_____	
Nerve Conduction Studies	[ ]	[ ]	_____	

23. Name of referring doctor _____
24. Name of Primary Care Physician _____

25. If you are a member of an HMO or other managed health care group, did you obtain a referral from your primary care physician for this visit? Yes No Not needed

Patient Demographic & Insurance Information Today's Date: ___/___/____

Patient Name: _____
Last First Middle Nickname

Date of Birth: ___/___/____ Social Security Number: ___-___-____ Sex: M / F Referred by:_____

Email: _____

Primary Phone Number: _____ Secondary Phone: _____

Mailing Address: _____ City _____State _____ Zip _____
Street Address: _____ City _____State _____ Zip _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Person Responsible for this account:
Name: _____ Relationship: _____ Phone:_____
Emergency Contact:
Name: _____ Relationship: _____ Phone:_____
Patient Employer: _____
Occupation: _____ Work Phone:_____

Primary Insurance:
Insurance Name:_____ ID Number:_____
Group/Plan Number: _____ Policy Holder Name: _____
Specialist Co-pay: $_____

Secondary Insurance:
Insurance Name:_____ ID Number:_____
Group/Plan Number: _____ Policy Holder Name: _____

Is this a work related injury? Yes / No **Is this injury related to a motor vehicle accident**? Yes / No
If Yes to either of the above: Name of company handling your claim: _____
Name of Adjustor:_____ Phone number for adjustor: _____
Claim number: _____ Date of Injury: _____
Attorney name: _____ Attorney Phone: _____

PATIENT FINANCIAL RESPONSIBILITY FORM Today's Date: ___/___/____

Patient Name: _____

Thank you for choosing Kenneth Wilson MD PC as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks
  - Charge for missed appointments without 24 hour notice

Patient Authorization:

- By my signature below, I hereby authorize Kenneth Wilson MD PC and the physicians, staff and hospitals associated with Kenneth Wilson MD PC to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or health care entities required to participate in my care.
- I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care. **By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:**
  - ☐ Record of alcohol and/or drug abuse.
  - ☐ Record of HIV (AIDS) result, diagnosis, and/or treatment.
  - ☐ Record of alcohol and/or psychological condition
- By my signature below, I hereby authorize assignment of financial benefits directly to Kenneth Wilson MD PC and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize Kenneth Wilson MD PC to communicate by mail, phone, and/or voice mail message, according to the information I provided below:

Please read and then choose YES or NO:

- If you are unavailable, may we leave medical information, such as appointment reminders, lab results and financial information on your voice mail or with someone at your residence? _____YES _____NO

If yes, please list name and relationship of person(s) with whom we are authorized to discuss your medical care and/or account:

Name	Relationship	Name	Relationship

Kenneth Wilson MD PC is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS PATIENT FINANCIAL RESPONSIBILITY FORM:

Name (please print) **Patient or Guardian Signature** **Date**