NEW PATIENT DEMOGRAPHICS

PATIENT INFORMATION	
Last Name: **Suffix:**	**DOB:**
First Name:	**Social Security #:**
Preferred Name:	**Gender: F M**
Middle Name:	**Home Phone:**
Mailing Address:	**Cell Phone:** Consent to text? Y N
Zip Code:	**Work Phone:**
City:	**Email:**
State:	**Contact Choice:** Home Cell Work Portal
Primary Care Provider: **Phone number:**	**Preferred Pharmacy:** **Location:**
Driver's License # : **State:**	**Primary Language:**
Race: American Indian or Alaska Native Asian Black Other Pacific Islander White Decline	
Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Decline to answer	
Marital Status: Married Single Divorced Separated Widowed Partner N/A	
How did you hear about ORCA? Provider (MD, DO, ND, PA, ND, PT) Name:____________________ TV Commercial Radio Commercial Internet search Website Insurance Company Other ______________ Friend Relative Neighbor Name:____________________________________	

INSURANCE INFORMATION Workers' Comp or Motor Vehicle Accident Claim *(If applicable)*	
Insurance Name: **Address:**	**Employer when injured:** **Address:**
Claim Number:	**Adjuster's Name:**
Injury date:	**Phone:**
Body part injured:	**Fax:**

Primary Insurance	Secondary Insurance
Insurance Name:	**Insurance Name:**
Member ID: *(VA patients, please use Social Security Number)*	**Member ID:** *(VA patients, please use Social Security Number)*
Group ID:	**Group ID:**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder DOB:	**Policy Holder DOB:**

Relationship to patient:	Relationship to patient:

GUARANTOR / GUARDIAN INFORMATION *(If other than patient)*	
Last Name: **Suffix:**	**DOB:** **Social Security #:**
First Name:	**Gender:**
Middle Name:	**Phone:**
Relationship to patient:	**Email:**
Address: ____ Same as patient	**Employer:**

EMERGENCY CONTACT INFORMATION

I give permission for ORCA to speak to the following people regarding my medical and/or billing information. I understand that when I designate another person to authorize treatment on my behalf, ORCA may release protected health information, relative to that decision, to that designated person. *Initial:* ____

Name:	**Name:**
Phone:	**Phone:**
Relationship:	**Relationship:**

Initial:	**ORCA Policy Acknowledgement**
____	I understand that, as the patient or primary guarantor, I am ultimately responsible for all charges, regardless of who holds my insurance policy, whether or not paid by insurance, and for all services rendered on my behalf or on behalf of my dependents. I authorize the named insurance company to pay Orthopaedic Research Clinic of Alaska (ORCA) for those charges I have not paid in full and which are filed by ORCA on my behalf. If the insurance company pays ORCA a fee I have already paid, I understand that I will be promptly reimbursed.
____	I authorize ORCA to release any medical information required by my insurance company or Workers' Compensation carrier for the processing of medical claims filed on my behalf.
____	I acknowledge that I have received ORCA's Notice of Privacy Practices, which describes how medical information about me or my dependent may be used and disclosed; that all information provided by the patient or guardian is deemed private in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
____	All patients are expected to check out with the front desk after each visit.

____

Signature of Patient or Responsible Party **Date**

ORCA Staff Initials: Date:

PEDIATRIC HEALTH HISTORY

Patient Name:		
HISTORY OF PRESENT ILLNESS		
AGE: ______Years ______Months	Attends Daycare? Yes No	Grade in School:
Sibling(s)/Age/Gender:		Height of Mother:
		Height of Father:
Pediatrician:	Referring Provider:	
What is the reason for today's visit?		
When did this problem first start?		
Is it better, worse or the same from when you first noted it?		
Are all vaccinations up to date?		
If not, list all vaccinations that are needed:		

PAST HISTORY	no	yes	If yes, please list:
Medical Problems?			
Operations?			
Medications?			
Drug Allergies?			
Latex Allergies?			n/a
Other Allergies?			
BIRTH HISTORY	**no**	**yes**	**Reason?**
Premature?			
Problems?			
Breech?			
Caesarian?			
NICU?			
Birth Place:			Hospital:
Birth weight: _____lbs. ____oz.			

DEVELOPMENTAL MILESTONES
At what age did the child: Roll over? ____months Sit up? ____months Crawl? ____months Walk? ____months ____n/a

FAMILY HISTORY OF PATIENT

Please describe any family history of medical problems related to patient's condition:

SOCIAL HISTORY OF PATIENT

Please describe any sports or extracurricular activities:

GENERAL CONDITIONS/TREATMENTS

yes	no		yes	no	
		Frequent or severe headaches			Dizziness
		Blurring or other problems with vision			Bladder problems or infection
		Hearing difficulty			Cancer
		Shortness of breath or wheezing			Diabetes
		Chest pain or palpitations			Blood clots or phlebitis
		Abdominal pain, nausea or vomiting			High blood pressure
		Abdominal bleeding			Stroke
		Depression			Thyroid gland disorder
		Persistent or repeated rashes			Epilepsy or seizures
		Repeated fevers			Weight loss or gain
		Arthritis			Does your child take Vitamin D?
		Other: Please explain briefly:			

OTHER QUESTIONS OR CONCERNS

HIPAA NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
  You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this.
  We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Correct your paper or electronic medical record
  You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.
- Request confidential communication
  You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit the information we share
  You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared your information
  You can ask us for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
  We will include the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make.) We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice
  You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you
  If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you believe your privacy rights have been violated
  You can complain if you feel we have violated your rights by contacting us using the information on this notice.
  You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
  We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

Our Uses and Disclosures

We typically use and share your information in the following ways:

- Treat you
  We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization
  We can use your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.
- Bill for your services
  We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues
  We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Do research
  We can use or share your information for health research.
- Comply with the law
  We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- Respond to organ and tissue donation requests
  We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
  We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
  We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With agencies that provide health oversight for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
  We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

HIPAA Compliance Officer: Ben Kennah, PA, Ben@orcaak.com