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:

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PATIENT HISTORY FORM

NAME: _____ Birthdate: ____/____/____
Last First M. I.

Location of current complaint:

Describe briefly your present symptoms:

Date of injury or onset:

Primary Care Provider: _____ Practice Name: _____

-Or-

Referring Provider: _____

Please list the names of other practitioners you have seen for this problem:

_____

Have you had a DEXA (Bone density) scan? ❑ Yes ❑ No Date performed: _____ Results: _____

Workmen's Comp Case? ❑ Yes ❑ No Date of Injury _____ Case #: _____

Is the injury the result of a Motor Vehicle Accident ❑ Yes ❑ No Date of Injury _____

ALLERGIES

Drug or seasonal allergies: ❑ None ❑ Yes (Please list below) Latex Allergy: ❑ Yes ❑ No

1) _____ Reaction: _____ 3) _____ Reaction: _____

2) _____ Reaction: _____ 4) _____ Reaction: _____

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

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PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Heart problems
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

SURGICAL HISTORY

Name of Operation	Date Performed	Surgeon and Location

PERSONAL HISTORY

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered ❑ Single

What is your current or past occupation? _____

Are you currently working? ❑ Yes ❑ No

Smoke Cigarettes or Marijuana ❑ Yes ❑ No Packs per day: _____

Former smoker ❑ Yes ❑ No When did you quit? _____

Total years you have smoked: _____

Alcohol: Drinks per week: _____

Recreational Drugs:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Weight gain: how much____
- ❑ Weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

_____

_____

_____

ORTHOPAEDIC RESEARCH CLINIC ALASKA

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