NORTHWEST ORTHOPAEDIC SPECIALISTS

Delivering Excellence

New Patient Form

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information will be strictly confidential

NAME (Last): _____ (First): _____ (MI): _____ ☐ Female ☐ Male

Social Security No.: _____ Marital Status: _____ Birth Date: _____ Age: _____

Mailing Address: _____ (City): _____ (State): _____ (Zip): _____

E-Mail Address: _____ Employer: _____

Please check your primary phone number.

PHONE: ☐ Home No.: (___) _____ ☐ Work No.: (___) _____ ☐ Cell No.: (___) _____

Referring Doctor: Last Name: _____ First: _____ Phone: (___) _____

Primary Care Physician: Last Name: _____ First: _____ Phone: (___) _____

If You Have a Cardiologist: Last Name: _____ First: _____ Phone: (___) _____

Language: ☐ English ☐ Spanish ☐ Russian ☐ Other Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian ☐ Hispanic or Latino ☐ Decline

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Person Responsible for Payment (if patient is a minor, under 18): _____

Street Address: _____ (City): _____ (State): _____ (Zip): _____

PHONE: Home No.: (___) _____ Work No.: (___) _____ Cell No.: (___) _____

Relationship to Patient: _____ Employer of Responsible Party: _____ Are Calls Allowed? ☐ Yes ☐ No

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NEAREST FRIEND / RELATIVE TO CONTACT IN CASE OF EMERGENCY, INCLUDE ALTERNATE PHONE NUMBER(S)

NAME (Last): _____ (First): _____ (MI): _____

Phone No.: (___) _____ Cell No: (___) _____ Relationship to Patient: _____

PLEASE PROVIDE A LIST OF PEOPLE WE ARE ALLOWED TO DISCUSS YOUR MEDICAL INFORMATION WITH (if applicable)

Name: _____ Phone: (___) _____

Name: _____ Phone: (___) _____

REASON FOR VISIT (List side): _____ INJURY DATE: _____

IS THIS PROBLEM WORK RELATED? ☐ Yes ☐ No If So, Employer at Time of Injury: _____

Industrial Insurance Carrier: _____ CLAIM NUMBER: _____

Insurance Carrier Address: _____ Insurance Phone Number: (___) _____

Is claim currently open? ☐ Yes ☐ No If no, when did claim close? ___ / ___ / ___ Disabled due to this condition? ☐ Yes ☐ No

If lost time due to this condition, what was the last date worked? _____

PRIMARY MEDICAL INSURANCE: _____ Policy # _____ Group # _____

Subscriber Name: _____ Subscriber Birth Date: ___ / ___ / ___ Subscriber Employer: _____

SECONDARY INSURANCE: _____ Policy # _____ Group # _____

Subscriber Name: _____ Subscriber Birth Date: ___ / ___ / ___ Subscriber Employer: _____

I hereby consent to receive calls and texts from Northwest Orthopaedic Specialists, P.S., or any business associate of Northwest Orthopaedic Specialists, P.S., with the phone number(s) provided or associated with my account, including wireless telephone numbers, so they may provide healthcare related information. I understand that I may be charged for calls and/or texts by my wireless carrier and methods of contact may include pre-recorded or texts/SMS/MMS messages and/or use of an automated dialing system.

☐ Yes ☐ No

I have completed the above information to the best of my knowledge. I request that payment of authorized benefits be made to me or on my behalf to Northwest Orthopaedic Specialists, P.S., for any services furnished to me. I authorize Northwest Orthopaedic Specialists, P.S., to release any medical information which may be requested to determine benefits through my above named insurance carrier, prepaid medical plan, government agency, or the Health Care Financing Administration. I understand that if any insurance does not pay in full for services provided by Northwest Orthopaedic Specialists, P.S., I assume liability for the unpaid portion. This agreement shall be governed and enforced in accordance with the laws of the State of Washington. Jurisdiction and proper venue for enforcement shall lie in Spokane County, State of Washington.

By signing below, I agree to the above statements, and I acknowledge receipt of the Notice of Privacy Practices of Northwest Orthopaedic Specialists, P.S.

X _____

SIGNATURE OF AUTHORIZED PERSON **DATE** **RELATION**

Northwest Orthopaedic Specialists, P.S., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.