PACIFIC SURGICAL, P.C.

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DATE: ___/____/____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE: (___) _____

CLINIC NAME: _____ CLINIC FAX: (___) _____

REFERRING PHYSICIAN: _____ PHONE: (___) _____

PATIENT INFORMATION (please print)

Name (First, MI, Last): _____ Gender: Male Female

Address: _____ Date of Birth: _____ Age: _____

City, State, Zip: _____ Social Security #: _____

Marital Status: Married Single □ Divorced □ Widowed

Primary Phone: (___) _____ type: _____ Work Phone: (___) _____

Is it ok to leave a message with your personal information or with anyone who might answer?_____

PATIENT EMPLOYMENT INFORMATION

Employed Retired Unemployed Other

Employer's Name: _____

Employer's Phone: (___) _____

Occupation: _____

EMERGENCY CONTACTS

NAME	RELATIONSHIP	PHONE

INSURANCE INFORMATION

Ins. Company: _____

Group/Policy #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Employer: _____

PRIVATE PAY

ID#: _____

Group/Policy Name: _____

Subscriber's SSN: _____

Subscriber's Date of Birth: _____

RESPONSIBLE PARTY ***(if patient is under 18yrs of age)***

Name: _____ Employer: _____

Address: _____ Home Phone: (___) _____

City, State, Zip: _____ Work Phone: (___) _____

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Medical Information

Name:_____ DOB:_____Date: _____

Reason for Visit:_____Are you ***PREGNANT***? □ Yes □ No If so, _____weeks

Medical Problems- please list**:**

_____

_____

Surgeries/Procedures- please indicate if you have ***previously*** had a surgery or procedure:

_____

_____

Social History: **Marital Status**: □ Single □ Married □ Divorced □ Widowed

Do you currently smoke?_____# packs/day:_____# years:_____Date quit:_____

Do you drink alcohol?_____Amount/day?_____# per week?_____Date quit:_____

Family History:

Strokes? □ Yes □ No WHO:_____
High Blood Pressure? □ Yes □ No WHO:_____
Diabetes? □ Yes □ No WHO: _____
Cancer? □ Yes □ No WHO: _____
Ulcer Disease? □ Yes □ No WHO: _____
Heart Disease? □ Yes □ No WHO: _____
Other: _____

Have you ever had MRSA? □ Yes □ No

Allergies: ***NONE*** Aspirin Morphine Penicillin Sulfa Latex Other:_____

Medications- Please list (including vitamins and naturopathic/over-the-counter):

Symptoms- Please circle if you are **currently** or **previously** experiencing any of the following:

Arthritis	Constipation	Fainting	Hepatitis/Jaundice	Shortness of breath	Weakness: arm/leg
Back problems	Cough (persistent)	Foot/Leg Ulcer	Hernia	Stomach ulcer	Wheezing
Bleeding disorder	Diarrhea	Gallstones	Hoarseness	Urination problems	
Blood in stool	Difficulty Swallowing	Headaches	Leg swelling	Vision problems	
Chest pain	Easy bruising	Hearing loss	Pancreatitis	Vomiting blood	

501 N. Graham St., Suite 580 • Portland, Oregon • 97227
Phone: (503) 528-0704 • Fax: (503) 528-0708

PACIFIC SURGICAL, P.C.

Insured Patient Payment Policy

Patient Responsibility:

- You are responsible for all charges resulting from treatment provided by Pacific Surgical, P.C. We bill most insurance carriers. However, primary responsibility for the account is yours. Your co-payment is always due at the time of service; any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us.
- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Insurance Billings:

- It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
- Medicare: We participate with Medicare. We will bill Medicare as your primary insurer. We will also bill your supplemental insurance provider.
- Medicaid: Please bring your current medical card with you to each appointment.

Authorization to Release Information:

- In obtaining payment for services, I authorize my healthcare provider, Pacific Surgical, P.C., to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including but not limited to: my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. For further information regarding disclosure of health information, please refer to the Notice of Privacy Information Practices available in our office.
- If I have been referred by, or am referred to another healthcare provider, I authorize Pacific Surgical, P.C. to release my medical information to this provider for continuing care.
- I also assign Pacific Surgical, P.C. all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by my insurance provider or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

I, or my appointed agent, have read, fully understand, and agree to the above statements. I can request a copy of this policy at any time.

_____	_____	_____
Patient's Name (please PRINT)	Patient's Signature	Date

If patient is under the age of 18 years, or is otherwise unable to sign, complete the following:
Patient is _____year(s) of age or is unable to sign because: _____

_____	_____	_____
Patient's Name (please PRINT)	Guarantor's Signature	Date

Sign below if disclosure of information is NOT authorized: Therefore, I agree to pay for costs of all treatment and services personally.

_____	_____	_____
Patient's Name (please PRINT)	Patient's Signature	Date

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PACIFIC SURGICAL, P.C.

Acknowledgment and Consent

I understand that Pacific Surgical, P.C. (hereafter referred to as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by The Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare; and
- perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written descriptions is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available at any time upon request.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.

_____	_____	_____
Patient's Name (please PRINT)	Patient's Signature	Date

If the Patient is under the age of 18 years, or is otherwise unable to sign, complete the following:
Patient is _____ year(s) of age or is unable to sign because: _____

_____	_____	_____
Patient's Name (please PRINT)	Guarantor's Signature	Date

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