

## Welcome To Our Office

### ***Patients Name***

First \_\_\_\_\_ M. Initial \_\_\_\_\_ Last \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Orthopaedic Problem \_\_\_\_\_ Date of Injury \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

***Primary Insurance*** (Circle one)      Health Ins.      PIP (auto)      Workers Comp.

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Adjuster Phone \_\_\_\_\_

Subscriber Name: First \_\_\_\_\_ M. Initial \_\_\_\_\_ Last \_\_\_\_\_

Relationship to patient / Subscriber is Patient \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_

Subscriber ID # Or Claim # \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

### ***Secondary Health Insurance***

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Adjuster Phone \_\_\_\_\_

Subscriber Name: First \_\_\_\_\_ M. Initial \_\_\_\_\_ Last \_\_\_\_\_

Relationship to patient / Subscriber is Patient \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

***Do you have another Health Insurance Policy?***      YES      NO

### ***Spouse, Parent or Legal Guardian - Fill out if appropriate***

Name: First \_\_\_\_\_ M. Initial \_\_\_\_\_ Last \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

***Your Preferred Pharmacy*** \_\_\_\_\_

**Address & Phone** \_\_\_\_\_

### ***Alternative Contact Other Than Above To Notify If You Have A Medical Emergency***

Name: First \_\_\_\_\_ M. Initial \_\_\_\_\_ Last \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Relationship to patient? \_\_\_\_\_ Phone \_\_\_\_\_

Thank you for choosing Kruger Clinic Orthopaedics, PLLC for your medical needs. We are committed to providing you with the best treatment available. The following is a statement of our financial policies.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance as a courtesy to you. Please be aware that some, and perhaps all of the services provided to you may be non-covered services and/or not considered medically necessary under your insurance plan. You will be responsible for all expenses excluded under your benefit plan. Specifically, Medicare and some private carriers do not cover some services such as braces, cast boots and other durable medical supplies as well as some surgical services such as assistant fees, pain pumps, implants (i.e. screws) and ice machines. We will only provide you with a service if we consider it medically necessary; therefore, if your insurance company arbitrarily determines that a service we have rendered to you is not medically necessary, you will be responsible for the bill.

ALL co-payments are due at the time of service. A billing fee may be assessed if you fail to pay your co-payment at the time of service.

We can bill for a MVA with a personal injury claim (PIP), if requested, but you are required to provide us with your medical insurance as secondary coverage, or a three hundred dollar deposit is required. Any overpayment will be refunded after your claims have been paid.

If you have no medical insurance a three hundred dollar deposit is due at the time of service and an additional deposit will be required if surgery is planned. For your convenience we accept cash, VISA or Master Card.

We are not contracted with DSHS or Medicaid, by signing below, you agree to receive and pay for all medical services rendered.

If your claim or reopening application with the Department of Labor and Industries (state or self insured) is denied or rejected you are responsible for your medical expenses.

We will bill your primary and secondary insurance for you. Any additional billing is your responsibility. Finance charges accrue at one percent per month for any unpaid balances.

By signing below I acknowledge and agree to receive and pay for all medical services as outlined. I assume financial responsibility for any balance due, attorney or collection costs and for services rendered that are not covered by my insurance due to lack of prior written referral or authorization. I authorize the release of any medical information required for this claim to be processed. This may include information regarding diagnosis or treatment of HIV, other sexually transmitted diseases, drug or alcohol use or abuse, mental illness or psychiatric treatment. I authorize Kruger Clinic Orthopaedics, PLLC to contact the Insurance Commissioner to aid in getting payment, if necessary. I further authorize my insurance benefits be paid directly to my health care provider at Kruger Clinic.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Legal Guardian, If Minor

# NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Judy at the clinic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt/review of the Notice of Privacy Practices.**

_____	_____	_____
Patient or legally authorized individual signature	Date	Time
_____	_____	
Printed Name if signed on behalf of patient	Relationship	
	(parent, legal guardian, personal representative)	

## CONSENT TO LEAVE MESSAGE

We at Kruger Clinic Orthopaedics are working to ensure that confidentiality regarding your medical information and care is maintained at all times. Because of these confidentiality concerns, we need your signature to allow us to leave a message about your medical care/procedure with someone in your household or on an answering machine.

Please complete this form and indicate your preference.

I, \_\_\_\_\_, give Kruger Clinic Orthopaedics permission to:  
Print Patient Name

Leave a message regarding my medical care/procedure on answering machine or with individual at following number(s):

- Yes Home# \_\_\_\_\_ Work# \_\_\_\_\_  
 No

Thank you for helping to serve you better.

_____	_____
Patient Signature (or legal guardian if patient is a minor)	Date

This form will be retained in your medical record.

Last Update: April 14, 2003

Kruger Clinic Orthopaedics, PLLC  
21600 Hwy 99, Suite #150  
Edmonds, Washington 98026-8047

## New Patient / New Problem Medical Questionnaire Orthopaedic Surgery (+ROS)

Appt. Date: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Patient name: \_\_\_\_\_

BP _____ / _____	Pulse _____	SAO2 _____	%
Temp _____	Hgt _____ / _____	Wgt _____	

Age: \_\_\_\_\_ Gender:  M  F Dominant hand:  R  L Did you bring x-rays?  Y  N

Who is your referring physician? (name) \_\_\_\_\_  None (self referral)

- ★ What is the main reason for this visit?  Pain  Numbness  Weakness  Swelling  Stiffness  Other: \_\_\_\_\_ (cc)
- ★ What body part is involved? One body part only: \_\_\_\_\_ If you have **more than one**, see receptionist. (location)
- ★ How long ago did it start? \_\_\_\_  days  weeks  months  years. Have you had a problem like this before?  Y  N (duration)

**Check the ONE box that best describes how your problem started. Then answer the questions below the box you checked.**

- NO INJURY** (Onset was:  Gradual  Sudden)  
 Why do you think it started? \_\_\_\_\_
- INJURY** ( Accident  Sport, NOT auto or work)  
 Date: \_\_\_\_\_ What sport: \_\_\_\_\_ School: \_\_\_\_\_  
 Where and how did it happen? \_\_\_\_\_
- INJURY AT WORK** Date: \_\_\_\_\_  
 From a  lift  twist  fall  bend  pull  reach
- WORK RELATED (BUT NO INJURY)**  
 Date: \_\_\_\_\_ How did your job cause this problem? \_\_\_\_\_
- AUTO ACCIDENT** Date: \_\_\_\_\_  
 How was your car hit? \_\_\_\_\_

MD Comments

★ On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10 (severity)

★ What is the quality of the pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning  No pain (quality)

The pain is now  constant  comes and goes (intermittent) **Does it wake you from sleep?**  Y  N (timing)

If your pain awakens you – how often? \_\_\_\_\_

★ Do you have  Swelling  Bruise  Numbness  Tingling  Weakness  Loss of control of bowel or bladder (assoc symps)

Joint giving out  Snapping  Popping  None  Other: \_\_\_\_\_

Since your problem started, it is:  Getting better  Getting worse  Unchanged (context)

What makes your problem **worse**?  Standing  Walking  Lifting  Exercise  Twisting  Lying in bed (modify)

Reaching  Bending  Squatting  Kneeling  Stairs  Sitting  Coughing  Sneezing  Other: \_\_\_\_\_

What makes your symptoms **better**?  Rest  Elevation  Ice  Heat  Other: \_\_\_\_\_ (modify)

What medications are you now (or previously) taking for this problem? \_\_\_\_\_ (modify)

Have you had any of these?  Injection  Brace  Physical Therapy  Cane/Crutch \_\_\_\_\_ (modify)

What tests/scans have you had for this problem?  X-rays  MRI  CAT scan  Bone scan  Nerve test(EMG/NCV)

Were you seen in the ER for this problem?  Y  N Which ER: \_\_\_\_\_ Date: \_\_\_\_\_

Are you here today as a result of the ER visit?  Y  N Who saw you in the ER (name): \_\_\_\_\_

Have you already had surgery for a problem in this same area recently or in the past?  Y  N Please list below:

Procedure #1: \_\_\_\_\_ Surgeon: \_\_\_\_\_ City: \_\_\_\_\_ Date: \_\_\_\_\_

Procedure #2: \_\_\_\_\_ Surgeon: \_\_\_\_\_ City: \_\_\_\_\_ Date: \_\_\_\_\_

Current work status?  Regular  Light duty(how long? \_\_\_\_\_)

Not working due to this problem  Disabled  Retired  Student

When is the last date you worked your regular job? \_\_\_\_\_

Are you currently receiving or plan to apply for:  Disability  Workman's Comp  Unemployment

**PRIMARY CARE PHYSICIAN** \_\_\_\_\_

# KRUGER CLINIC ORTHOPAEDICS REVIEW OF SYSTEMS

Patient name \_\_\_\_\_

## Medical History

Primary Care Physician \_\_\_\_\_

Please list all your surgeries and hospitalizations including the date.

**Previous Surgeries** None \_\_\_\_\_

**Previous Hospitalizations** None \_\_\_\_\_

## Review of Systems

**Medications and Dosage** \_\_\_\_\_

**Allergies to Medications** None Yes What? \_\_\_\_\_

\_\_\_\_\_ **LATEX Allergy** Yes No \_\_\_\_\_

**Medical conditions currently being treated for** None \_\_\_\_\_

Do you have a **history of**, are **being treated for**, or **take medications for** any of the following symptoms:

**Musculoskeletal:** none or:

gout back pain neck pain joint pain joint swelling muscle cramps muscle weakness  
stiffness arthritis fracture osteoporosis  
other \_\_\_\_\_

**Gastrointestinal:** none or:

nausea/vomiting stomach pain jaundice irritable bowel reflux high cholesterol heartburn  
blood in stool ulcers  
other \_\_\_\_\_

**Endocrine:** none or:

weight change frequent thirst frequent urination always hot or cold hypothyroidism  
hyperthyroidism type I diabetes type II diabetes  
other \_\_\_\_\_

**General:** none or:

frequent fever eating disorder fatigue weight loss loss of appetite  
other \_\_\_\_\_

**Eyes:** none or:

blurred vision double vision vision loss abnormal sensitivity to light glaucoma corrective lenses  
other \_\_\_\_\_

**Ears/Nose/Throat:** none or:

earache ringing hearing loss/aid nasal congestion nosebleeds trouble swallowing  
hoarseness sinusitis  
other \_\_\_\_\_

**Cardiovascular:** none or:

chest pains palpitations high blood pressure labored breathing or shortness of breath stroke  
difficulty breathing while lying down swelling in ankles and legs phlebitis light-headedness or fainting  
heart attack other \_\_\_\_\_

**Respiratory:** none or:  
chronic cough shortness of breath excessive mucous from the lungs coughing up blood wheezing  
asthma sleep apnea COPD  
other \_\_\_\_\_

**Genitourinary:** none or:  
difficulty beginning urination excessive urination during the night painful urination incontinence  
kidney stones decreased kidney function blood in urine kidney problems  
other \_\_\_\_\_

**Skin:** none or:  
frequent rashes skin ulcers dryness itching  
other \_\_\_\_\_

**Neurologic:** none or:  
temporary paralysis weakness headaches dizziness numbness seizures  
light-headedness or fainting trembling or shaking loss of consciousness  
head injury, when \_\_\_\_\_ other \_\_\_\_\_

**Psychiatric:** none or:  
drug/alcohol problem memory loss panic attacks/anxiety sleep disorder depression  
other \_\_\_\_\_

**Heme/Lymphatic:** none or:  
abnormal bruising easy bleeding HIV/AIDS hemophilia enlarged lymph glands  
hepatitis A hepatitis B hepatitis C  
other \_\_\_\_\_

Blood Clots No Yes Anesthesia Problems No Yes Bleeding Problems No Yes

**Pregnancies:** # Pregnancies \_\_\_\_\_ # Children \_\_\_\_\_ Could you possibly be pregnant at this time? Yes No

**Social History** Single Married Divorced Widowed What level of education did you complete? \_\_\_\_\_  
How many people live with you? \_\_\_\_\_

Smoker No Yes How much each day? #packs \_\_\_\_\_ #years \_\_\_\_\_ Cigarettes Cigars Pipe Chew  
Alcohol No Yes Rarely Drinks/week \_\_\_\_\_  
Dominant Hand? Right Left  
Occupation \_\_\_\_\_

Do you like your job? No Yes Do you plan to being working in six months? No Yes

Any HIV or hepatitis risk factors such as IV drug use or sexual habits? No Yes

Blood transfusions No Yes Year \_\_\_\_\_

Recreational Drugs No Yes What? \_\_\_\_\_

**Family History** If a blood relative has suffered from any of the following conditions please place the proper initial in the space provided.

Father=F Mother=M Grandparent=G

Diabetes \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Cancer \_\_\_\_\_ Type? \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Gout \_\_\_\_\_

Heart Disease \_\_\_\_\_ Arthritis \_\_\_\_\_ Anesthesia Problems \_\_\_\_\_ Rheumatoid Arthritis \_\_\_\_\_ Stroke \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_ L&I# \_\_\_\_\_

Signature: \_\_\_\_\_ MD Review: \_\_\_\_\_