UPPER EXTREMITY HAND & MICROSURGERY CENTER
3366 NW Expressway, Suite 700, Oklahoma City, OK 73112 Phone: (405) 945-4888

(PRINT CLEARLY)

Last Name: _____ **First Name:** _____ **Middle Initial:** _____ **Age:** _____

Race: American Indian/Alaska Native - Black/African American - White/Caucasian - Asian - Pacific Islander

Ethnicity: Hispanic/Latino - Non-Hispanic/Latino Gender: MALE FEMALE

Are you: (circle) RIGHT LEFT Handed. You are being seen for: (circle) LEFT RIGHT BOTH Extremities

Occupation:_____ **How long doing this type of work :**_____

Smoker: YES NO How long/Amount: _____ **Alcohol: YES NO How long/Amount:** _____

(CIRCLE THOSE THAT APPLY) Heart Disease High Blood Pressure Lung Disease Thyroid Disease Diabetes

Arthritis Asthma HIV Hepatitis STAPH MRSA Depression Psychiatric Conditions

Other conditions (please specify): _____

Current Medications:_____

_____

List controlled/pain medications you have been taking for a long time: _____

Allergies: _____ **Hobbies:** _____

Surgical History:_____

_____

Date of Injury/Accident OR Onset of Symptoms/Condition: _____ **Place Accident Occurred:** _____

Is this work related? YES NO Are you currently working ? YES NO How long have you been off work: _____

What other physicians have you seen for this condition: _____

For this condition, did you have: (circle): X-Rays EMG MRI CT Scan Chiropractic Treatment

GRIP	**Date:**_____	**Date:**_____	**Date:**_____	**Date:**_____	**Date:**_____
	R ____ **L** ____	**R** ____ **L** ____	**R** ____ **L** ____	**R** ____ **L** ____	**R** ____ **L** ____

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Last Name: _____ **First Name:** _____ **Middle Initial:** _____ **Age:** _____

How did you hear about us?_____

Primary Care Physician (PCP): _____ **Referring Physician:** _____

Cardiologist: _____ **Pulmonologist:** _____

PERSONAL INFORMATION:

Social Security #: _____ **Date of Birth:** _____ **Marital Status: S M D W**

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Other Phone:** _____

SPOUSE/PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ **Relationship to Patient:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Other Phone:** _____

PRIMARY INSURANCE:

Insurance Company:_____ ***Subscriber's Name:***_____ ***DOB:***_____

Insured's Employer:_____ ***ID/Policy#:***_____ ***Group#:***_____

COPAY? Yes_____ ***No***_____

SECONDARY INSURANCE

Insurance Company:_____ ***Subscriber's Name:***_____ ***DOB:***_____

Insured's Employer:_____ ***ID/Policy#:***_____ ***Group#:***_____

COPAY? Yes_____ ***No***_____

AUTHORIZATION:

The information I have provided, to the best of my knowledge, is true and correct. I authorize the release of any medical information requested by the physician or insurance carrier. I authorize release to claim examiners, adjusters, or nurse case managers employed by the insurance carrier listed. I understand that this authorization can be revoked at any time by me. I authorize payment of medical benefits to the Upper Extremity Hand & Microsurgery center for services rendered from this day forth.

Signature: _____ **Date:** _____

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I, _____ recognize and acknowledge that ALL charges or co-pays for treatment and/or diagnosis are due and payable ***at the time of service.*** **(With the exception of approved workers comp services provided.)** If other arrangements are necessary, please discuss this with the receptionist PRIOR to your treatment/ diagnosis.

To help us with filing your insurance, we need the following:

- Insurance company claim forms (only if required by your company)
- Policy numbers (group and identification)
- Mailing address to mail the claim
- Phone numbers (to verify coverage/second opinion, etc)
- Employees or insureds statement (please fill in and sign)
- Name, social, and birth date of insured (if not patient)

PLEASE BE ADVISED:
Insurance companies are responsible only to you, the insured, and not the doctor. Although we will make every effort to facilitate your insurance billing, the patient/insured party is **ULTIMATELY RESPONSIBLE FOR THE TOTAL CHARGES INCURRED.** Thank you for your time and consideration.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.
I understand that as part of my health and medical care, the center originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand this information serves as:

- a basis for planning my care and treatment
- a means of communicating among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bills
- a means for a third party payor to verify that services were billed as actually provided.
- A tool for routine operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing. I understand and have been provided with a **Patient Privacy Notice** that provides a more compete description of information uses and disclosures. I understand that I have the right to review the **Patient Privacy Notice** prior to signing this consent. I understand that the center reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the center is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you....that the information authorized for release may included records which may indicate the presence of influenza, a communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as AIDS.

In addition to the release outlined above, information may be released to the following individuals for the indicated purposes.

_____ _____

_____ _____

I requested the following restrictions to the use and or disclosure of my health information: _____

_____

I authorize Dr. Rayan or Dr. Porembski to take pictures of my hand for educational purposes. YES_____ NO_____

Signature: _____ Date: _____