UPPER EXTREMITY HAND & MICROSURGERY CENTER

3366 Expressway, Ste 700 OKC, OK 73112 Phone (405) 945-4888

CHILD ONLY

Referred by: ______________________ (Circle One) Friend Relative Insurance Company Doctor

Has the child been seen here before? ________

PATIENT INFORMATION: (Please Print) Marital Status: S M D W Sex: MALE FEMALE

Last Name: ______________________ First Name: ____________________ Middle Initial: _____

Social Security Number: __________________ DOB: ______________ Age: _______

Address: ________________________ City: ______________ State: _____ Zip Code: ________

Home Phone: ______________________ Cell Phone: ____________________

PARENT INFORMATION:

Mother: ____________________________ DOB: _____________ SSN: _______________

Address: ____

Home Phone: ______________________ Cell Phone: ________________________

Employer: ____________________ Work Phone: ______________ Dept: __________________

Father: ____________________________ DOB: _____________ SSN: _______________

Address: ____

Home Phone: ______________________ Cell Phone: ________________________

Employer: ____________________ Work Phone: ______________ Dept: __________________

PERSON TO NOTIFY IN CASE OF EMERGENCY (**<u>person other than child's parent & not living with you</u>**)

Name: ______________________________ Relationship to Patient: ____________________

Address: ____

Home Phone: ________________ Cell Phone: ________________ Other: ________________

INSURANCE INFORMATION (Please give card(s) to receptionist for copying)

Primary

Insurance Company: _______________ Subscriber: ________________ SSN: ______________

Employer: __________________ ID#: _______________ Group#: ________ DOB: ________

Secondary

Insurance Company: _______________ Subscriber: ________________ SSN: ______________

Employer: __________________ ID#: _______________ Group#: ________ DOB: ________

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. ***Payment is due at time of service. This includes all copays and/or deductibles per your insurance policy.**

Signature: ___________________________________ (Parent/Guardian) Date: ______________

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(PLEASE PRINT CLEARLY)

Last Name: ____________________________ First Name: ___________________________ Middle Initial: _____

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

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

(Please circle) Are you: RIGHT LEFT Handed Age: ____________

You are being seen for: (Please circle) LEFT RIGHT ~ Thumb Finger Hand Wrist Arm

Onset of Symptoms/Condition: ____________________________ or Date of Injury: ___________________________

Place Accident Occurred: ______________________________ How: ____

Referring physician: _________________________________ Primary Care Physician: _________________________

Seen in Emergency Room at: ____

For this condition, did you have: (Please circle): X-Rays MRI CT Scan Splint Cast

Medical History: (Please circle those that apply) Heart Disease Thyroid Disease Diabetes Hepatitis

HIV Positive Asthma Depression Psychiatric Conditions Others: _____________________________________

Syndromes: ____

Congenital systemic abnormalities: Heart GI CNS GU Others: ____________________________

Congenital Musculoskeletal abnormalities: ____

Are there any congenital problems with any other family member? Yes No

If yes, please explain: ____

Surgical History: ____

Current Medications: ____

Allergies: ____

Hobbies: ____

MATERNAL HISTORY:

Systemic Diseases: ____

Medications: ____ Smoker: Yes No

Pregnancy: Full Term: Yes No Complications: Yes No Delivery: Natural Surgical

Serious Illness: ____

Medications: ____

Ultrasound: Photographs or Video during pregnancy? Yes No

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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: ______________________