New Patient Intake Form

Date: _____

Patient Information

Name: _____ _____ ____ **Date of Birth**: _____
Last *First* *Middle Initial*

Address: _____ **Age**: _____ **Sex:** ○ Male / ○ Female

City: _____ **State**: _____ **Zip**: _____

Primary Phone Number: _____ ○ Home ○ Mobile ○ Work

Secondary Phone Number: _____ ○ Home ○ Mobile ○ Work

Email Address: _____

Marital Status: ○ Single ○ Married ○ Partner ○ Divorced ○ Separated ○ Widowed

Employment Information

Current Work Status: ○ Employed ○ Unemployed ○ Student ○ Retired ○ Disabled

If you are not working - when was the last time you worked? _____

Job Title / Occupation (the more specific the better): _____

Employer: _____ **Phone**: _____

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

Chief Complaint

Please provide a brief detailed description of the symptoms or problem you are currently experiencing

_____

_____

Between 0 and 10, what number best represents the intensity of your pain: ____ out of 10
(0 = no pain, 5 = moderate pain, and 10 = the worst pain imaginable)

Which side does this affect? ○ Right ○ Left ○ Both **Hand Dominance**: ○ Right ○ Left

Emergency Contact

Name: _____ **Relationship**: _____ **Phone**: _____

Primary Care Physician *(PCP)*

Name: _____ **Phone**: _____ **Fax**: _____

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

Referring Physician *(physician who referred you to Bellevue Hand Surgery)*

Did your PCP refer you? ○ Yes ○ No, a different provider referred you - **please list below**

Name: _____ **Specialty**: _____ **Phone**: _____ **Fax**: _____

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

Preferred Pharmacy

Name: _____ **Phone**: _____

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

Insurance Information

PRIMARY Insurance: _____ **Subscriber ID**: _____ **Group #**: _____

Primary Subscriber: ○ Self ○ Spouse ○ Parent ○ Other: _____

Name of Subscriber: _____ _____ _____ **DOB of Subscriber**: _____
Last *First* *Middle Initial*

SECONDARY Insurance: _____ **Subscriber ID**: _____ **Group #**: _____

Primary Subscriber: ○ Self ○ Spouse ○ Parent ○ Other: _____

Name of Subscriber: _____ **DOB of Subscriber**: _____
Last *First* *Middle Initial*

Release of Benefits Information

Lifetime Authorization: I authorize my insurance benefits be paid directly to Bellevue Orthopedic Physicians PLLC / Bellevue Hand Surgery for any services furnished to me by Bellevue Orthopedic Physicians PLLC / Bellevue Hand Surgery. I am responsible for any balance due. I authorize any holder of medical information of my own to release to my insurance company and its agents any information needed to determine benefits or the benefits payable for related services. _____ **(Initial here)**

Are you here because you were injured at your place of work? ○ No ○ Yes

***If you answered yes (above), please complete the following sections:**

Work Related Injury

(Leave blank if not applicable)

Date of Injury: _____ **Last Day Worked**: _____

Claim Manager: _____ **Claim Number:** _____

Phone Number: _____ **Email Address**: _____

Who is managing this claim?

○ Washington State Department of Labor & Industries ○ OWCP / FECA ○ CorVel ○ Eberle Vivian

○ Gallagher Bassett ○ Sedgwick ○ Other: _____

Are you here because you were injured in a motor vehicle accident? ○ No ○ Yes

***If you answered yes (above), please complete the following sections:**

Motor Vehicle Related Injury

(Leave blank if not applicable)

Date of Injury: _____

Insurance Provider: ○ Allstate ○ Geico ○ Liberty Mutual ○ Progressive

○ State Farm ○ USAA ○ Other: _____

Claim Number: _____ **Adjuster:** _____

Phone Number: _____ **Email Address**: _____

Current Health Condition

Approximately when did this problem begin (date of injury): _____

What seemed to be the initial cause: _____

_____

Does your condition impact: ☐ Work ☐ Sleep ☐ Other: _____

Symptoms: ☐ Instability ☐ Numbness ☐ Pain ☐ Stiffness ☐ Swelling

Other: _____

If you have pain, please check the most appropriate description:

☐ Aching ☐ Burning ☐ Dull ☐ Heavy ☐ Sharp ☐ Stabbing ☐ Throbbing

How are your symptoms changing?

○ Better Gradually ○ Better Rapidly ○ Worse Gradually ○ Worse Rapidly ○ Staying the Same

Does any of the following improve / reduce your symptoms?

☐ Rest ☐ Ice ☐ Heat ☐ NSAID ☐ Splinting ☐ Massage

Does any of the following worsen your symptoms?

☐ Activity ☐ Cold ☐ Pressure Other: _____

Have you had any diagnostic imaging, studies, or treatments for this problem?

☐ Arthrogram ☐ Bone Scan ☐ CT ☐ MRI ☐ Nerve Study (EMG) ☐ Surgery ☐ Therapy ☐ X-ray

☐ Other: _____

If you had any diagnostic imaging, studies, or treatments, what were the results? _____

_____

Have you had any therapeutic treatments for this problem?

☐ Acupuncture ☐ Bracing ☐ Massage Therapy ☐ Platelet-Rich Plasma (PRP) Injection

☐ Stem Cell Injection ☐ Steroid Injection ☐ Surgery Other: _____

If you had therapeutic treatments, what were the results? _____

_____

Social History

Height: _____ Weight: _____

Do you currently smoke?	○ No	○ Yes	Amount per day: _____
Have you ever smoked?	○ No	○ Yes	Year you quit: _____
Do you drink alcohol?	○ No	○ Yes	Drinks per week: _____
Do you consume caffeine?	○ No	○ Yes	Drinks per week: _____
Do you follow a specific diet?	○ No	○ Yes	Name of diet: _____
Have you ever had a drug problem?	○ No	○ Yes	Year you quit: _____
Have you ever had a drinking problem?	○ No	○ Yes	Year you quit: _____
Do you exercise?	○ No	○ Yes	Times per week: _____
Do you experience balance issues?	○ No	○ Yes	
If 65+ have you fallen in the past 2 years or fallen resulting in injury in the past 12 months?	○ No	○ Yes	
If 65+ have you had a Pneumococcal vaccine in the past 12 months?	○ No	○ Yes	
Have you had a flu shot in the past 6 months?	○ No	○ Yes	
Do you have any children?	○ No	○ Yes	How many: _____

Race: ○ African American ○ American Indian / Alaskan Native ○ Asian ○ Caucasian ○ Pacific Islander ○ Other: _____

Ethnicity: ○ Hispanic / Latino ○ Non-Hispanic Latino ○ Decline to Answer

Highest Level of Education: _____

Current Medications/Supplements

Medication	Dose	Frequency – i.e. once per day	Reason you are taking it?

*If additional space is needed please ask the front desk for an additional form for medications/supplements or attach your own list.

Allergies

Please focus on allergic reactions – rather than side effects when answering the following questions

Common ALLERGIC reactions include	**Common minor side effects include** (nonallergic)
• Hives • Itchy Rash • Difficulty Breathing • Swelling in the Face, Tongue, and Throat	• Dizziness • Excessive Sleepiness • Nausea • Upset stomach

Are you allergic to latex? ○ No ○ Yes

Do you have any known drug allergies? ○ No ○ Yes

If yes, please indicate medication(s) you are allergic to and specify your allergic reaction

☐ Iodine: _____ ☐ NSAIDs: _____ ☐ Penicillin: _____ ☐ Sulfa Drugs: _____

Other(s): _____

Health Conditions (Check all that apply)

☐ Asthma	☐ Bleeding Disorder	☐ Cancer	☐ Cardiac Stents
☐ Chronic Lung Disease	☐ Chronic Pain	☐ Congestive Heart Failure	☐ Coronary Heart Disease
☐ Diabetes	☐ DVT / Clotting Disorder	☐ Heart Attack	☐ Heart Burn / Reflux
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ High Blood Pressure
☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Neck Fusion
☐ Neurological Disorder	☐ Pacemaker	☐ Rheumatoid Arthritis	☐ Sleep Apnea
☐ Spinal Cord Stimulator	☐ Taking Blood Thinners	☐ Thyroid Disease	

Other: _____

Surgical History

Have you had prior surgery that is related to your symptoms? ○ No ○ Yes

If yes, please describe the surgery or surgeries* **Year

_____ _____

_____ _____

Description of any other surgeries not related to your current problem

Example: Appendectomy, Coronary artery bypass, etc. **Year**

_____ _____

_____ _____

_____ _____

Have you experienced any anesthesia complications? ○ No ○ Yes, please describe: _____

_____

Family Health History

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

☐ Arthritis: _____ ☐ Bleed Easily: _____ ☐ Cancer: _____

☐ Diabetes: _____ ☐ Epilepsy: _____ ☐ Glaucoma: _____

☐ Heart Disease: _____ ☐ High Blood Pressure: _____ Lung Disease: _____

☐ Stroke: _____ Other: _____

Add additional details for any positive conditions you selected above: _____

_____

Review of Systems

In the past month, have you had any of the following conditions? (Check all that apply)

Dental ☐ Chipped or loose teeth ☐ Dental Implants Other: _____	**Ears** ☐ Ringing in ears ☐ Loss of hearing Other: _____	**Eyes** ☐ Loss of vision ☐ Dryness Other: _____	**General** ☐ Recent weight gain: how much____ ☐ Recent weight loss: how much____ ☐ Fatigue / Weakness ☐ Fever / Night Sweats
Heart and Lungs ☐ Chest pain ☐ Palpitations ☐ Shortness of breath Other: _____	**Kidney / Urine / Bladder** ☐ Blood in urine ☐ Difficulty urinating ☐ Frequent or painful urination Other: _____	**Muscle / Joints / Bones** ☐ Joint pain ☐ Muscle weakness Other: _____	**Nervous System** ☐ Headaches ☐ Dizziness ☐ Numbness or tingling Other: _____
Psychiatric ☐ Anxiety ☐ Depression ☐ Irritability ☐ PTSD ☐ Thoughts of suicide	**Skin** ☐ Redness ☐ Rash Other: _____	**Stomach and Intestines** ☐ Nausea ☐ Vomiting ☐ Persistent diarrhea ☐ Blood in stools Other: _____	**Throat** ☐ Frequent sore throats ☐ Difficulty in swallowing Other: _____

Add additional detail for any conditions indicated above: _____

_____

By signing you are acknowledging that you have completed this form to the best of your knowledge

Name: _____ **Relationship**: _____

Printed Name - Patient or legally authorized individual (Parent, Legal Guardian, Personal Rep)

Signature: _____ **Date**: _____

Patient or legally authorized individual