

## PATIENT REGISTRATION

### PATIENT INFORMATION

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex  M  F  
First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mark an **X** by your preferred phone

Would you prefer  text,  email, or  phone call for appt reminders?

Home Phone (\_\_\_\_) \_\_\_\_\_  Cell Phone (\_\_\_\_) \_\_\_\_\_  Work Phone (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_ Marital Status:  Married  Single  Divorced  Widowed  
Employment Status:  Employed  Retired  Self-Employed  Full-time Student  Unemployed  
Employer: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

### INSURANCE INFORMATION (Please provide your insurance cards to the receptionist)

Insurance Company: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Subscriber's Social Security # \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

### Responsible Party (if signed on behalf of the patient) Parent Guarantor Other

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
SS # \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_  
State \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

### PHARMACY INFORMATION

\*\*\*Please do not choose mail-order pharmacy\*\*\*

Pendleton Bi-Mart  Pendleton Safeway  Pendleton Rite-Aid  Pendleton Wal-Mart  
 Pendleton Walgreens  Yellowhawk Pharmacy  Other \_\_\_\_\_

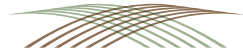
### EMERGENCY CONTACT & Guarantor Information

Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship: \_\_\_\_\_

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her service as described realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_



NORTHEAST OREGON  
SURGICAL CLINIC

Dr. Andrew Bower

## NOTICE OF PRIVACY PRACTICES (HIPAA)

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 except those involved in your continued care 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 any information about it by contacting our office manager. A fee may apply.

**Please list any individuals (family members, etc.) to whom you give us permission to discuss and/or release your medical records to:**

\_\_\_\_\_

Authorized individual

\_\_\_\_\_

Authorized individual

In order to ensure your privacy, you will be asked to provide your photo ID which will be copied and retained within your chart for identification purposes.

Before our office will release your information we will take reasonable precautions to ensure they are indeed one of the people or part of an entity which you have listed above and/or are involved with your direct medical care. Your information is automatically released to offices, hospitals, labs, etc. for the purpose of treatment, payment or health care operations, per the HIPAA Privacy Act.

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 is available for you in our waiting room.

**By my signature below I acknowledge I was given the opportunity to receive the Notice of Privacy Practices and I wish for my information to be released to those individuals or entities indicated above.**

\_\_\_\_\_

Patient signature (or legally-authorized individual)

\_\_\_\_\_

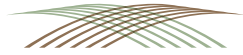
Date

\_\_\_\_\_

Printed name (if signed on behalf of the patient)

\_\_\_\_\_

Relationship



As a service to our patients, we would like to outline our policy toward the payment for services.

1. Patient co-payments are expected at the time of the appointment. If a patient is not aware of his or her co-pay amount, the average co-pay of \$25 will be collected at the time of service. If adjustments are to be made, the company will do so promptly after the Explanation of Benefits is received from the third party payer.
2. Although we are billing your insurance companies as a courtesy to you, we hold you responsible for your account. If the insurance information you provide us is incorrect, you will be responsible to pay your account in full within 30 days, you may then bill your insurance company yourself to obtain reimbursement.
3. All accounts are to be paid off in full within 30 days unless prior payment arrangements have been established in writing.
4. If the problem for which you are seeing the physician involves litigation, such as may result from an automobile or work-related accident, be advised that we do not wait for payment until litigation is settled.
5. Your signature authorizes us to contact references in the event it becomes necessary to locate you.
6. Past due accounts are required to pay cash in full at the time of service.
7. All credit balances may be held as credits against future services rendered unless credit refunds are requested in writing by the patient and patient care has been deemed complete by the physician.
8. A one-time processing charge of \$25 and a 1 % per month (9% per year) will be imposed on all accounts 60 days past due.
9. A \$25 fee will be charged on all checks returned to the bank for lack of funds and are subject to Oregon Law, ORS 30.700, which states legal action can be taken for three (3) times the amount of the check or \$100, whichever is greater.
10. In the event you do not give at least a 24-hour notice prior to canceling an appointment and/or if you do not show for a scheduled appointment or procedure, there will be a \$25 administrative scheduling fee assessed.
11. Dr. Andrew Bower's charges and fees are irrespective of St. Anthony Hospital's or other provider's charges and fees.
12. Financial Aid agreed to by St. Anthony Hospital or other providers does not apply to our office, or to Dr. Andrew Bower's charges.
13. Patient portion of charges are determined by your individual insurance policy. The patient responsibility portion of charges must be collected by our office per a legally binding contract that Dr. Andrew Bower holds with them. This contract allows us to be a "Preferred Provider" and/or "Participating Provider".
14. Your deductible, co-payment and/or co-insurance are all determined by your insurance company. If you have any questions or concerns regarding these items, please contact your insurance company.
15. You are encouraged to contact the Clinic Administrator if you have any questions regarding your account or if you do not fully understand these policies.

**By my signature below, I acknowledge that I was given the opportunity to read these financial policies and to ask questions. I now fully understand the financial policies.**

\_\_\_\_\_  
PATIENT SIGNATURE (OR LEGALLY-AUTHORIZED INDIVIDUAL)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME (IF SIGNED ON BEHALF OF THE PATIENT)

\_\_\_\_\_  
RELATIONSHIP



Dr. Andrew Bower

tel (541) 966.1001 fax (541) 966.1195  
2474 SW Perkins Avenue Pendleton, OR 97801  
www.surgeonbower.com

## HEALTH QUESTIONNAIRE

Date \_\_\_ / \_\_\_ / \_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_

Referring Doctor \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

**Reason for today's visit** \_\_\_\_\_

List any serious **childhood** illnesses (polio, rheumatic fever, etc.) \_\_\_\_\_

List all **allergies** to medications, iodine or latex \_\_\_\_\_

List all **medications** (include over the counter medication and dose) you are currently taking \_\_\_\_\_

Check box if you need to attach a list of medications to this form

List all **past serious medical problems** \_\_\_\_\_

List all previous **surgery** (and date) \_\_\_\_\_

How much **alcohol** do you drink a day?  Don't drink alcohol  
 \_\_\_shots/day  \_\_\_cans/day  \_\_\_ounces/day

Do You use **tobacco**?  Yes  No –  Don't Use Tobacco  Never smoked  
If yes:  Cigarettes: \_\_\_packs/day  Cigars: \_\_\_cigars/day  Chew/Snuff: \_\_\_cans/day

Do you drink **caffeine**?  Yes  No How much/day \_\_\_\_\_

Does your religion prohibit blood transfusions?  Yes  No

Do you use street, herbal or non-prescription drugs?  Yes  No

Have you had any exposure to Hepatitis, TB or HIV?  Yes  No

Females: Are you pregnant?  Yes  No

Do you have loose, chipped, false teeth, bridgework or crowns caps?  Yes  No

## HEALTH QUESTIONNAIRE (page2)

Name: \_\_\_\_\_

### Family History:

Have any of your relatives (maternal/paternal grandparents, parents, brothers, or sisters had:

- Cancer (list type) \_\_\_\_\_
- Colon Cancer \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Abnormal reaction to anesthesia \_\_\_\_\_
- Colonic polyps \_\_\_\_\_

### Have you ever had:

- An abnormal reaction to anesthesia \_\_\_\_\_
- A colonoscopy (when, by whom and results) \_\_\_\_\_
- \_\_\_\_\_
- An upper endoscopy (EGD) \_\_\_\_\_
- An EKG (when and where) \_\_\_\_\_
- When did you last have your blood drawn and where \_\_\_\_\_

### Chief Complaint/History of Present Illness:

What are the symptoms that brought you to the office today? \_\_\_\_\_

When did these symptoms first begin? \_\_\_\_\_

Is this an on-the-job injury?  Yes  No

If you are experiencing pain, please describe the location of the pain: \_\_\_\_\_

What makes the pain go away or get better? \_\_\_\_\_

- What makes the pain worse? \_\_\_\_\_
- On the pain chart of zero to 10, zero is no pain at all and 10 is unbearable pain, please **mark the level** of your pain: right now \_\_\_\_\_ when you walk \_\_\_\_\_ when you sit \_\_\_\_\_ when lifting something \_\_\_\_\_ when you bend \_\_\_\_\_ when you lay flat \_\_\_\_\_
- Is your pain:  sharp  dull  constant  intermittent  burning

Have you had any images pertaining to this problem:

(x-rays, CT scan an MRI etc....)  Yes  No

- Where and When? \_\_\_\_\_
- Why: \_\_\_\_\_

## HEALTH QUESTIONNAIRE (page 3)

Name: \_\_\_\_\_

**Review of Systems: Circle if you have any of these issues:**

General: weight loss, weight gain, fever, chills, fatigue, night sweats

Eyes: glaucoma, glasses, contacts, cataracts

Ears/Nose/Throat: earache, hearing loss, ringing in the ears, hearing aids, nose bleeds, hoarseness, throat pain, neck stiffness, lump or swelling in the neck

Cardiac: chest pain or discomfort, artificial heart valve/stent, fast heart rate, Palpitations, high blood pressure, pacemaker

Gastrointestinal: difficulty swallowing, constipation, heartburn, nausea, abdominal pain, diarrhea, black or bloody stools, poor appetite, ulcers, gallstones

Genitourinary: painful or difficult urination, increased urinary frequency, blood in urine, kidney stones

Musculoskeletal: artificial joint or joint pain (specify joint) \_\_\_\_\_  
• metal in body  No  Yes : Where? \_\_\_\_\_

Neurological: numbness, weakness, seizures, loss of memory, poor balance

Psychological: sleep disturbances, anxiety, depression, claustrophobia, panic attack

Endocrine: excessive thirst, excessive sweating, diabetic

Other: \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY OFFICE STAFF**

BP \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SAT \_\_\_\_\_ PLS \_\_\_\_\_ TMP \_\_\_\_\_

General: \_\_\_\_\_

Head, ears, eyes, nose, throat: \_\_\_\_\_

Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_

Lymph nodes: \_\_\_\_\_ Neurologic: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Genitalia: \_\_\_\_\_

Vascular: \_\_\_\_\_ Breasts: \_\_\_\_\_