

# Patient Registration

How did you hear about us?  Newspaper  Friend/Family  Website  Other: \_\_\_\_\_

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Emergency #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Ethnicity  Hispanic  Non-Hispanic Primary Language: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Primary Insurance Information

Subscriber's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance #: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

## Secondary Insurance Information

Subscriber's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance #: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Consent for Care**

I consent to and authorize all medical treatments and procedures as recommended and performed by providers within Snoqualmie Valley Hospital District (SVHD). I understand I have the right to decline any specific recommended treatments.

**Payment Agreement**

I understand I am responsible for full payment of all charges and any co-payments are due on the day of service. I authorize the payment of benefits from my insurance to be paid directly to SVHD. I understand some or all of my health care record may be released to my insurance carrier or liable third party payer for purpose of obtaining payment for services rendered to me. If uninsured, partial payment for services is due at time services are rendered.

**Privacy Practices Acknowledgment**

We will not disclose your personal health information to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes these processes in detail and is available by request at any time.

\_\_\_\_\_  
Signature of Patient/Authorized Representative

\_\_\_\_\_  
Date

# Osteoporosis History

## Patient Information

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of Last Bone Density Scan and Name of Facility: \_\_\_\_\_

## Gynecologic History *(women only)*

### Circle Yes (Y) or No (N)

Y N Are/were your periods regular between the ages 18 and 40 years?

Y N Have you experienced irregularity or absence of menstrual cycles?

Y N Have you had a hysterectomy? If yes, what year or age \_\_\_\_\_ Ovaries removed? \_\_\_\_\_

Y N Have you entered menopause? If yes, which year or age \_\_\_\_\_

## Social History

Y N Do you drink caffeinated products? If yes, how many per day \_\_\_\_\_

Y N Do you drink alcoholic beverages? If yes, how many drinks per week \_\_\_\_\_

Y N Do you smoke cigarettes? If yes, how many packs per day \_\_\_\_\_

Y N Do you exercise regularly? If yes, how often per week \_\_\_\_\_

## Osteoporosis Risk Factors

Y N Have you ever broken any bones? If yes, what age/which bones \_\_\_\_\_

Y N Have you had surgery on your lower back or hips?

If yes, when, and specify which areas \_\_\_\_\_

Y N Does anyone in your immediate family have osteoporosis? *(parents or siblings)*

Relationship and age \_\_\_\_\_

Y N Have you lost height of more than one inch?

## Medications & Medical History

Y N Are you now under going hormone replacement therapy, taking pills or using patches?

If yes, which type \_\_\_\_\_

Y N Have you ever been on hormone replacement therapy?

If yes, which type and when \_\_\_\_\_

Y N Have you ever had kidney failure, dialysis, transplant or chronic kidney disease?

If yes, please explain \_\_\_\_\_

## Diseases and Medications that can Impact your Risk of Osteoporosis

Check all that apply and Circle if this is Current (C) or Past (P) History

### Diseases

- Cancer C P
- Eating Disorder C P
- Hypocalcemia C P
- Hyperparathyroidism C P
- Hyperthyroid, Hypothyroid C P
- Kidney Stones C P
- Endometriosis C P
- Hemophilia C P
- Alcoholism C P
- Lactose Intolerance C P
- Malabsorption/Small Bowel Disease C P
- Paget's Disease of the Bone C P
- Radiation/Chemotherapy C P

### Medications *(Write How Long)*

- Actonel C P \_\_\_\_\_
- Fosamax C P \_\_\_\_\_
- Dilantin C P \_\_\_\_\_
- Anti-Cancer C P \_\_\_\_\_
- Diuretics C P \_\_\_\_\_
- Methotrexate C P \_\_\_\_\_
- Steroids (*prednisone, etc.*) C P \_\_\_\_\_
- Thyroid Meds. C P \_\_\_\_\_
- Vitamin D C P  
Milligrams per day? \_\_\_\_\_
- Calcium C P  
Milligrams per day? \_\_\_\_\_

## **Clinic Payment Policy**

Snoqualmie Valley Hospital District (SVHD) believes that a good medical provider/patient relationship is based on good communication. We strive to provide information to our patients that clearly describe any illness, diagnosis or course of treatment. We also want to provide timely, accurate information regarding the billing arrangements we use in our practice.

Our offices are contracted with more than thirty medical insurance companies including individual, group, and HMO carriers. If you are a member of one of these plans we will bill your insurance company directly. If your insurance plan requires a co-pay or deductible for the services you receive we will collect these amounts at the time of service.

If your particular insurance plan is not one of those that we are contracted with you may still ask us to bill the company, however, insurance companies typically require that the patient pay a larger percentage of the bill if they receive services outside their contracted network. For services rendered inside or outside a particular network the co-pay is still paid at the time of service.

To determine if your insurance plan is currently contracted with SVHD please call our Clinics Billing Office at (425) 831-2310.

If you are not covered under an insurance plan you are expected to pay in full at the time of service unless payment arrangements are made prior to the service. A \$75.00 pre-payment will be collected before services are rendered. Our Clinics Billing Office is open during normal business hours (8am to 5pm) and will assist in developing a payment plan if that is required.

You may be dismissed from care for a delinquent account. We are required by state and federal regulations to employ every reasonable means to collect for our service. State regulations also require that collection fees are added to the past due amount and that they be paid by the person(s) responsible for the debt.

# Personal Health Information Communication Methods

## Patient Information

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Permissions *(Please check ALL that apply)*

The Hospital District may leave a reminder and/or detailed message using the following methods:

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Text Message: \_\_\_\_\_

Email: \_\_\_\_\_

List Preferred Communication Method: \_\_\_\_\_

The Hospital District may leave a message and/or discuss my medical information with the following individual(s):

Name & Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name & Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change any of my preferences.

\_\_\_\_\_  
Signature of Patient/Authorized Representative

\_\_\_\_\_  
Date