PORTLAND SURGEONS, P.C.

Main Office: 503.215.3550 Fax 503.215.3551
5050 N.E. Hoyt Street, Suite 523 Portland, Oregon 97213
www.pdxsurgeons.com

- **Dr. Jordana Gaumond, Dr. Scott Soot, Dr. Kelvin Yu and Dr. Karen Zink** are **Portland Surgeons, PC.** We are located in **Providence Professional Plaza at 5050 NE Hoyt Street, Suite 523.**

- Convenient parking is located in the Providence Professional Plaza parking structure and valet parking is available at no charge.

- Enclosed are patient registration and medical questionnaire forms for your convenience. Please complete these forms and bring them to your appointment for faster service.

- A map and driving directions are enclosed to ease your way.

- Please bring your photo ID and insurance card(s) and any copay required.

We are looking forward to serving you in our new location. Please call our office at **503-215-3550** with any questions.

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I-84 EAST

Exit at NE 58th Ave (Exit 3)
Turn right onto NE Glisan St.
Turn right onto NE 49th St.

I-205 NORTH

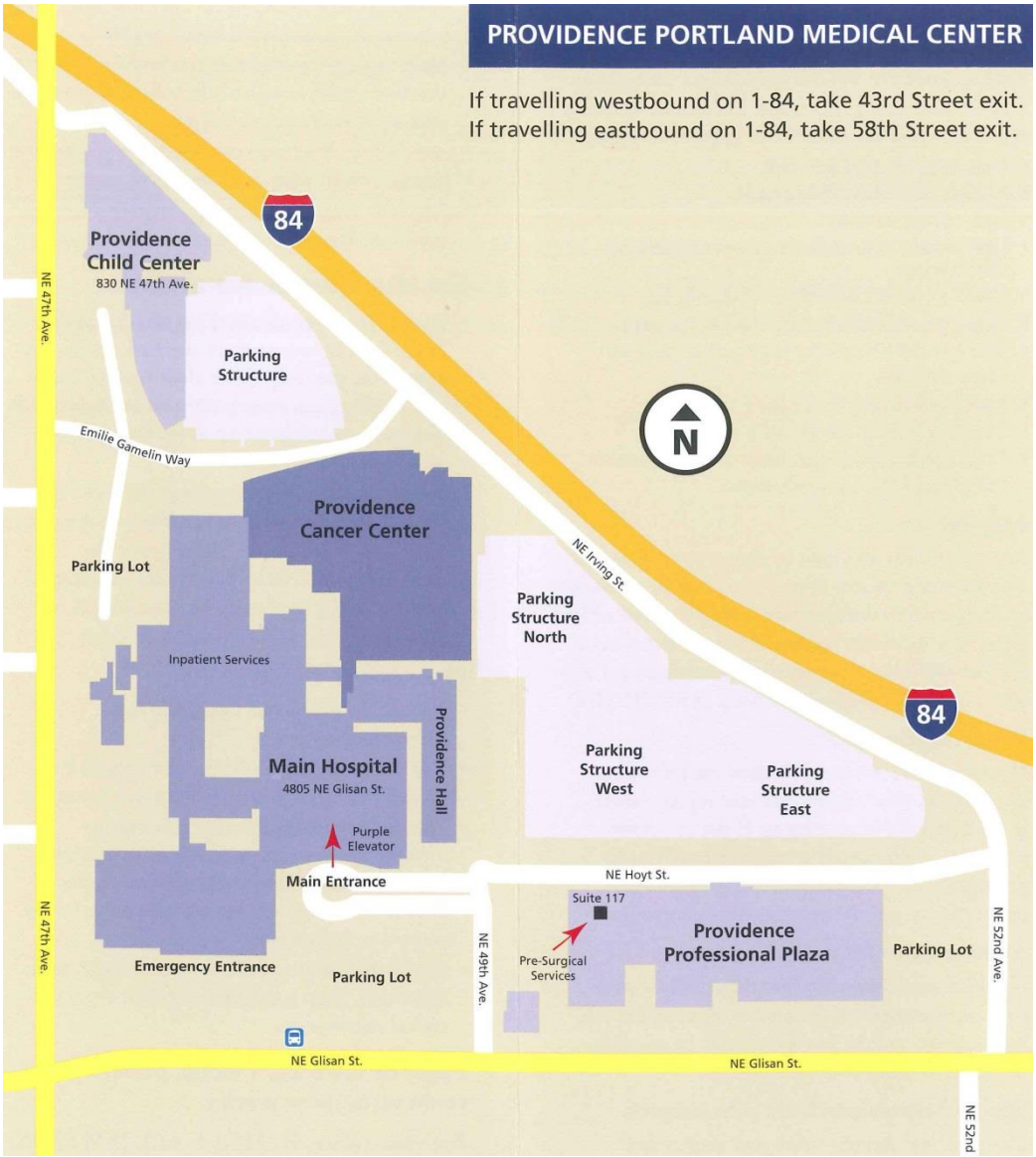
Exit at NE Glisan St. (Exit 21A)
Turn left onto NE Glisan St.
Turn right onto NE 49th Ave

I-84 WEST

Exit at NE 43rd Ave (Exit 2)
Turn right onto NE Halsey St.
Turn right onto NE 47th St.
Turn left onto NE Glisan St.
Turn left onto NE 49th St.

I-205 SOUTH

Exit at NE Glisan St. (Exit 21A)
Turn right onto NE Glisan St.
Turn right onto NE 49th Ave



PORTLAND SURGEONS

If not enough room, please use back of form for notations

Name_____ Date of birth _____

Reason for office visit_____

1. Past medical history; please include chronic illness, medical conditions, mental health conditions, disabilities, and prior hospitalizations. (Month and year if possible):

_____
_____
_____
_____

2. Past surgical history; please include any surgery requiring general, spinal, epidural or local anesthesia. Include month and year. Females; please include C-sections:

_____
_____
_____
_____

3. If you have ever been diagnosed with cancer please list treatments with month and year:

_____
_____

4. Medications and dosages: Prescriptions, vitamins, herbs, aspirin, and over the counter medication

_____
_____
_____
_____
_____

5. Have you ever taken blood thinners (Heparin, Coumadin, Lovenox, etc), if yes, state reason and dates_____

_____

6. Allergies to medications? Please list medication and reactions or symptoms; this includes any adverse reactions to anesthesia _____

_____
_____

7. Personal History: If using any of the following, list quantity, how often used, and how long. If you have in the past used, please list stop date.

Tobacco_____
Alcohol _____
Recreational Drugs_____

8. Family History: List medical problems and ages of parents, brothers, sisters and children. If deceased, please list cause of death. List any major medical problems in the family.

_____
_____
_____

9. Is there a family history of cancer? Please list type of cancer for parents, grandparents, siblings, aunts, uncles, and children.

_____
_____
_____

PORTLAND SURGEONS
REVIEW OF SYSTEMS

Please circle any items that you have today

GENERAL: Fevers, chills, sweats, fatigue, feeling of general discomfort, unexplained weight loss, loss of appetite

EYES: Blurring, double vision, irritation, discharge, vision loss, eye pain, light sensitivity

EAR/NOSE/THROAT: Ear pain or discharge, ringing in the ears, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, difficulty swallowing

CARDIOVASCULAR: Chest pains, forcible heart beats, fainting, shortness of breath with exercise, shortness of breath when lying down, shortness of breath at night, swelling of the feet or ankles

RESPIRATORY: Cough, shortness of breath, excessive mucus, coughing up blood, wheezing

GASTROINTESTINAL: Nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, black tarry stools, blood in stools, jaundice

GENITOURINARY: Vaginal discharge or sores, menstrual irregularity, painful intercourse, leakage of urine

MUSCULOSKELETAL: Back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis

SKIN: Rash, itching, dryness, suspicious lesions

NEUROLOGICAL: Transient paralysis, weakness, numbness, seizures, fainting, tremors, vertigo

PSYCHIATRIC: Depression, anxiety, memory loss, mental disturbance, suicidal thoughts, hallucinations, paranoia

ENDOCRINE: Cold intolerance, heat intolerance, excessive thirst, excessive appetite, excessive urination, weight change

HEME/LYMPHATIC: Abnormal bruising, bleeding, enlarged lymph nodes

ALLERGIC/IMMUNOLOGIC: Hives, hay fever, persistent infection, HIV exposure

CHAPERONE: Would you like a chaperone in the exam room during your visit? Yes No

OTHER: _____

Patient Name_____ Date_____

PORTLAND SURGEONS

FEMALE HEALTH HISTORY

1. Have you ever been previously diagnosed with a breast mass, lump, cyst, or abscess?

_____

If yes: What was the location? Right, left, or both _____

Did you have a breast biopsy or other breast surgery? _____

What was the diagnosis? (If known)_____

Have you had previous breast surgery? (Biopsy, cyst drainage, abscess drainage, mastectomy, breast implants, breast reduction)_____

2. Have you previously been diagnosed with breast cancer? Give month and year of diagnosis:

_____

If yes: Did you have surgery? _____Diagnosis and dates_____

Did you have radiation? _____ Dates of treatments? _____

Did you have chemotherapy? _____ Dates of treatments? _____

Were you given hormone therapy? (Tamoxifen, Arimidex, Anastrozole)_____

3. Have you ever experienced any of the following?

- ❑ Breast pain; right, left, or both_____
- ❑ Nipple discharge; right, left, or both? _____
  Was the fluid bloody? _____
  Was it spontaneous? (No pressure on the breast or nipple)_____
  Does the drainage only appear with pressure? _____
  How often does it appear? _____
  Is it associated with your menstrual cycle? _____
- ❑ Retraction of nipples? _____

4. Have you had a prior mammogram? Please give month, year, and location:

_____

5. Do you have a family history of breast cancer? Please state which relative:

_____

6. Any current or past use of hormone replacement therapy? _____

7. First day of your last menstrual cycle: _____

8. Age at first menstrual cycle: _____

9. Number of pregnancies: _____
   Age at the time of each pregnancy: _____
   Number of deliveries: _____

Name: _____ Date: _____

PORTLAND SURGEONS - Patient Registration

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: ____ Zip: _____

Home phone #: _____ Mobile phone #: _____

Emergency contact: _____ Telephone: _____

Relationship to contact: Spouse, Child, Grandparent, Parent, Grandchild, Sibling, Neighbor, Roommate, Friend, Partner, Other

Email address: _____ Social security number: _____

Marital status: Married, Divorced, Single, Separated, Other Ethnicity: Hispanic, Non-Hispanic, Unknown

Race: African American, Asian, Caucasian, American Indian, Hawaiian, Pacific Islander, Unknown, Decline

Preferred Language: _____

Who referred you? _____ Telephone: _____

Primary Physician (PCP): _____ Office Phone: _____

Preferred Pharmacy: _____ Telephone: _____

Pharmacy Address: _____

Employer/Occupation: _____ Work Phone #: _____

Responsible Party for Payment (**Must be filled out if patient is less than 18 years of age**.)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Telephone (Home): _____ Telephone (Other): _____

Primary Insurance

Insurance Name: _____ Copay: $_____

Ins. Address: _____ City: _____ State: ____ Zip Code: _____

ID No. or Social Security No.: _____ Group or Plan No.: _____

Policy Holder/Subscriber Name: _____ Relationship: _____

Subscriber date of birth: _____

Secondary Insurance

Insurance Name: _____ Co-pmt $: _____

Ins. Address: _____ City: _____ State: ____ Zip Code: _____

ID No. or Social Security No.: _____ Group or Plan No.: _____

Policy Holder/Subscriber Name: _____ Relationship: _____

Subscriber date of birth: _____

PORTLAND SURGEONS

Payment Policy

Patient Responsibility:

- You are responsible for all charges resulting from treatment provided by Portland Surgeons. We bill most insurance carriers; however, primary responsibility for the account is yours. Your co-payment is always due at the time of service; any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us.
- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Insurance Billings:

- It is your responsibility, (or that of the financially responsible party), to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible the pay the charges.
- Medicare: We participate with Medicare. We will bill Medicare as your primary insurer. We will also bill your supplement insurance provider.
- Medicaid: Please bring your current medical card with you to each appointment. If you are restricted to a primary care physician by Oregon's Medical Assistance Program or Washington's Department of Social and Health Services, *you must obtain a referral* prior to receiving care from a specialist.

Check Returned:

It is our office policy to charge a **$25.00** fee for checks that are returned.

Copays:

Copays are due on the day service is rendered, **$10.00** extra will be charged if for any reason you need to be billed for your copay.

Authorization to Release Information:

- In obtaining payment for services, I authorize my healthcare provider, Portland Surgeons, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim.
- If I have been referred by, or am being referred to, another healthcare provider, I authorize Portland Surgeons to release my medical information to this provider for continuing care.
- I also assign Portland Surgeons all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

Patient Name (Please Print)	Patient's Signature	Date

IF PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is _____ year(s) of age or is unable to sign because: _____

Signature	Relationship to Patient	Date

Sign Below if Disclosure of Information is NOT Authorized:

Therefore, I agree to pay for costs of all treatment and services personally.

Signature of Guarantor	Date	Signature of Patient	Date

Portland Surgeons, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF THE JOINT NOTICE OF PRIVACY PRACTICES

Name:

Date of Birth:

Purpose: This form is used to document the Portland Surgeons, P.C. Notice of Privacy Practices was given to the patient or their personal representative, as required by federal law.

By signing this form, you acknowledge receipt of the Portland Surgeons, P.C. Notice of Privacy Practices. Our notice provides information about how we may use and disclose your protected health information. We encourage you to review the notice carefully.

I acknowledge receipt of Portland Surgeons, P.C. Notice of Privacy Practices

Signature: _____ Date: _____
(Patient or personal representative)

If you are signing as a personal representative, please complete the following.

Print personal representative's name: _____

Relationship to patient: _____

For Official Portland Surgeons, P.C. Use Only

Inability to Obtain Acknowledgement

To be completed only if a signature is not obtained. Describe the good faith efforts made to obtain the individuals' acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

Signature of Portland Surgeons, P.C. representative:

_____ Date: _____

Portland Surgeons Wants You To Know:

You Have A Choice

Oregon law (ORS 441.098) requires us to inform you that:

- You have a choice of where to go when you are referred for a diagnostic test, health care treatment or services.
- When a referral is made, you have the right to talk about your options of where you may go, and the right to choose where you would like to have a test, treatment or service done.
- Your referral will not be denied, limited or withdrawn if you choose another facility.
- It is your responsibility to determine your medical insurance coverage for a test, treatment or service.

More information can be found at www.oregon.gov. Look for the Oregon Administrative Rules (OAR), Oregon Health Authority, Public Health Division, Chapter 333, Division 72, "Healthcare Practitioner Referrals."

_____ _____

Signature Date

Clinic Family and Friends Authorization Form

Patient Name:_____ **Date of Birth:** _____

As a patient of Portland Surgeons, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. This information can be changed or revoked with your permission at any time.

I give permission for information related to my current health status to be discussed with:

Name	**Relationship**	**Telephone**
Name	**Relationship**	**Telephone**
Name	**Relationship**	**Telephone**

_____ **Not applicable - No pertinent family**

_____ **Do not share my medical information with any family or friends.**

_____ **Do NOT share with**

Name	**Relationship**

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

Signature: _____ _____

Patient or Personal Representative **Today's Date**