KYM ORTHOPEDICS PLLC
Patient Demographic Information

Please print:

Patient Name: Prefers to be called: Mailing Address: Apt #: Street:		Responsible Party Name (if minor): Zip Code:	City: □ □ Lewiston □□ Clarkston Other City:	State: □ ID □ □ WA Other State:
Sex: ☐ Female ☐ Male	Home Phone: Cell Phone: e-mail:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Date of Birth: Social Security #:		
Employer Name: Address: City/State/Zip: Occupation: Work Phone:		Spouse Name: Spouse's Birthdate: Spouse's Employer:	Emergency Contact Name: Phone #: Address:	

Information Required by Medicare (must complete even if you don't have Medicare insurance)			
Preferred Language: □ English □ Spanish □ Other	Spanish, Hispanic or Latino ethnicity: □ Yes □ No □ Declined to answer	Race: □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander	□ White/Caucasian □ Other □ Declined to answer

Please complete below if patient is a minor:		
Father's Name:	Father's Address: □ Same as Patient Street:	Father's Employer:
Home Phone:	City:	Father's Social Security #:
Cell Phone:	State: Zip Code:	Father's Birthdate:
Work Phone:		
Mother's Name:	Mother's Address: □ Same as Patient Street:	Mother's Employer:
Home Phone:	City:	Mother's Social Security #:
Cell Phone:	State: Zip Code:	Mother's Birthdate:
Work Phone:		

Does this visit pertain to an injury or accident that we will bill to Worker's Compensation or other insurance?

□ Yes □□ No **If yes, complete the following accident / injury information:**

□□ Auto Accident	If Auto Accident, Date of Injury:	State:
	Claim #:	Insured Name:
□ □ On the Job Injury	If on the Job Injury, Date of Injury:	State:
	Name of Employer:	Industrial Insurance Co:
	Claim #:	
□ □ Other Accident	If other Injury, Date of Injury:	State:
	Describe What and How Injured:	

Insurance / Financial Information:

Do you have medical insurance?	If no, do you agree to:
□□ Yes □□ No	□ regular monthly payments by check □ regular monthly credit card payments

If you have medical insurance, please list: We need this information regardless of whether or not it was accident.

Primary Insurance Name:	Policy #:	Group #:
Name of Policy Holder:	Policy Holder Birthdate:	Policy Holder Employer:

Secondary Insurance Name:	Policy #:	Group #:
Name of Policy Holder:	Policy Holder Birthdate:	Policy Holder Employer:

Medicare Patients Only: Please complete the following information:

How are you enrolled in Medicare?	Is Medicare your primary or secondary insurance plan?
□ based on age □ based on disability □ based on ESRD (end stage renal disease)	□ primary □ secondary

Yes	No			
		1. Are you receiving Black Lung (BL) Benefits? If yes, date benefits began:		
		2. Are your services at Kym Orthopedics to be paid by a government program such as a research grant?		
		3. Are your services at the Kym Orthopedics to be paid by the Dept of Veterans Affairs (DVA)?		
		4. Are you currently employed?		
		5. Is your spouse currently employed?		
		6. Do you have group health coverage based on your own or a spouse's current employment?		
		Yes	No	7. If you answered yes to #6, does the employer that sponsors your group health coverage employ 20 or more employees?
		8. Are you covered under the group health plan of a family member other than your spouse?		

Patient Label

KYM ORTHOPEDICS PLLC

Acknowledgement of Financial Responsibility: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for all fees incurred in my treatment and services. I also authorize the doctor or insurance company to release any information required for this claim.

Consent for Treatment: I hereby give my consent for the authorized personnel of Kym Orthopedics PLLC to evaluate and, if appropriate; render subsequent treatment in accordance with the plan of care authorized by my physician (if applicable) or by my personal authorization. I understand I have the right to refuse any procedure or treatment.

Consent for Minor: As the above named minor's parent or legal guardian, I hereby give my consent for the authorized personnel of Kym Orthopedics PLLC to evaluate and, if appropriate, render subsequent treatment in accordance with the plan of care authorized by patient's physician (if applicable) or by my personal authorization.

Privacy Notice Confirmation: I understand that by signing below, I am certifying that I have been offered the Notice of Privacy. I understand that I have the right to review the notice prior to signing. I understand that the Kym Orthopedics reserves the right to change their notice and practices and will publish any changes in the lobby. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand, that unless I object, Kym Orthopedics PLLC may disclose protected health information to a member of my family, relative, close friend, or other person who is involved in my healthcare or payment of my healthcare. Kym Orthopedics will limit the disclosure to the protected health information relevant to that person's involvement in my healthcare or payment.

Patient/ Parent Signature: _____ Date _____

Witness: _____