Melissa R. Kinder, MD
Hand and Reconstructive Surgery Northwest

Reason for visit: _____ (if injury, **date of injury**): _____

Patient Information

Patient's Full Name: _____
(last) (first) (middle)

Sex: _____ SSN#: _____ DOB: _____

Address: _____

Phone: _____ OK to leave message? **Y / N** OK to receive text appointment reminders? **Y / N**

Email: _____ OK to email appointment reminders? **Y / N**

If Minor, name & relationship of parent or guardian: _____

Guardian's DOB: _____ **Guardian's SSN**: _____

Employer: _____ Address: _____ Ph.#: _____

Emergency Contact Name & Phone Number: _____ Ph.#: _____

Referred to Clinic by: (circle one) Hospital / E.R. (name) _____ Other: _____

Insurance Information Does the Patient have Medical Insurance? **Yes / No**

On the Job Injury? **Y / N** If so, Name of Employers Insurance Co. _____

Address: _____ Ph.# _____ Claim# _____

Primary Medical Insurance: _____ ID #: _____ Group#: _____

Name of Subscriber: _____ DOB: _____ SSN# _____

Relationship to Subscriber: _____ Employer: _____ Ph# _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Name of Subscriber: _____ DOB: _____ SSN# _____

Relationship to Subscriber: _____ Employer: _____ Ph# _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Melissa R. Kinder, M.D., or my insurance company to release any information required to process my claim(s).

_____ _____
Patient or Authorized Persons signature **Date**

NOTE: Receipt of this paperwork does not establish patient physician relationship and does not direct any responsibility to Dr. Kinder or any entity of Hand and Reconstructive Surgery Northwest.

Melissa R. Kinder, MD

Hand and Reconstructive Surgery Northwest

PAST, FAMILY, SOCIAL, HEALTH HISTORY FORM

NAME: _____ **DATE OF BIRTH:** _____ **TODAYS DATE:** _____

Thank you for allowing us to participate in your hand and reconstructive care. Please complete the following information to assist us in gathering information about your health history.

HAND INJURY ONLY

Are you [LEFT] / [RIGHT] **handed**

Which hand is injured [LEFT] / [RIGHT] **Have you ever injured this hand before** [YES] / [NO]

HEALTH MAINTENANCE:

ALLERGIES please list allergy & reaction:

Allergen:_____Reaction:_____ Allergen:_____Reaction:_____

Allergen:_____Reaction:_____ Allergen:_____Reaction:_____

Allergen:_____Reaction:_____ Allergen:_____Reaction:_____

Allergen:_____Reaction:_____ Allergen:_____Reaction:_____

*** **HEIGHT**_____ **WEIGHT**_____ ***

PAST MEDICAL HISTORY: ***Please check the box to the RIGHT for all that apply***

Arthritis (Rheumatoid)		Emphysema		Kidney Disease/Failure	
Arthritis (Osteo)		Fibromyalgia		Kidney Stones	
Asthma		Fractures (bones)		Osteoporosis	
Bladder/Kidney Problems		GERD/Heartburn		Polymyalgia Rheumatica	
Blood Clot (leg/arm)		Glaucoma		Pneumonia	
Blood Clot (lung)		Gout		Prostate (enlargement)	
Blood Transfusion		Heart Attack		Seizure/Epilepsy	
COPD		Hepatitis- Type A		Skin Problems, Type:	
Coronary Artery Disease		Hepatitis- Type B			
Depression		Hepatitis- Type C		Sleep Apnea/CPAP/BIPAP	
Diabetes Type I		Hepatitis- Other		Stomach Ulcer	
Diabetes Type II (adult onset)		High Blood Pressure		Stroke	
Cancer, Type:		High Cholesterol		Thyroid (nodule)	
		Hip Fracture		Thyroid (overactive) hyper	
Other (list)		HIV/AIDS		Thyroid (underactive) hypo	
		Irritable Bowel Syndrome		Tuberculosis	

NOTE: Receipt of this paperwork does not establish patient physician relationship and does not direct any responsibility to Dr. Kinder or any entity of Hand and Reconstructive Surgery Northwest.

Melissa R. Kinder, MD

Hand and Reconstructive Surgery Northwest

NAME: _____ **DATE OF BIRTH:** _____ **TODAYS DATE:** _____

SURGICAL HISTORY:

Please list any surgeries or medical procedures that you have had.

_____

_____

_____

_____

_____

FAMILY HISTORY: Please check all that apply

MEDICAL CONDITION	MOTHER	FATHER	SISTER	BROTHER	DAUGHTER	SON
Alcoholism						
Anemia						
Anesthesia problems						
Arthritis						
Asthma						
Bleeding problems						
Cancer, type:						
Depression						
Diabetes, type I (childhood onset)						
Diabetes, type II (adult onset)						
Epilepsy (seizures)						
Glaucoma						
Heart Attack (coronary artery disease)						
High Blood Pressure (hypertension)						
High Cholesterol (hyperlipidemia)						
Kidney Disease						
Lupus						
Mitral Valve Prolapse						
Osteoarthritis						
Osteoporosis						
Rheumatoid arthritis						
Stroke						
Thyroid disorder						
Tuberculosis						
Other:_____						

NOTE: Receipt of this paperwork does not establish patient physician relationship and does not direct any responsibility to Dr. Kinder or any entity of Hand and Reconstructive Surgery Northwest.

Melissa R. Kinder, MD

Hand and Reconstructive Surgery Northwest

NAME: _____ **DATE OF BIRTH:** _____ **TODAYS DATE:** _____

SOCIAL HISTORY:

SUBSTANCES

Tobacco Use: please circle one

Cigarettes

Never Smoker Current Smoker packs/day____# of yrs _____ Former Smoker quit date: _____

Other Tobacco: please circle if applicable

Pipe Cigar Chew

Alcohol Use: please circle one

Do you drink alcohol? No / Yes number of drinks: _____ per_____ (week, month, year)

Drug Use: please circle one

Do you use recreational drugs? No / Yes Type(s):_____

Have you ever used needles? No / Yes

Exercise: please circle one

Do you exercise daily? No / Yes Weekly? No / Yes

What kind of exercise? _____

Occupation: _____

Type of work/job requirements: Sedentary Physical Labor Other _____

Do you have a Primary Care Physician? If so please tell us who and provide their phone number:

NOTE: Receipt of this paperwork does not establish patient physician relationship and does not direct any responsibility to Dr. Kinder or any entity of Hand and Reconstructive Surgery Northwest.

Melissa R. Kinder, MD

Hand and Reconstructive Surgery Northwest

NAME: _____ **DATE OF BIRTH:** _____ **TODAYS DATE:** _____

Please list any current or recent prescription and over the counter medication you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS:

Please circle yes or no if you have recently experienced any of the following

Fever	YES	NO
Chest pain	YES	NO
Shortness of breath	YES	NO
Unexplained weight loss	YES	NO
Palpitations	YES	NO
Other musculoskeletal pain	YES	NO
Changes in appetite	YES	NO
Changes in bowel or bladder habits	YES	NO
Easily bruising or bleeding	YES	NO
History of blood clots	YES	NO

NOTE: Receipt of this paperwork does not establish patient physician relationship and does not direct any responsibility to Dr. Kinder or any entity of Hand and Reconstructive Surgery Northwest.

Confirmation of receipt of Office Procedures, Policies, Privacy Practices and Consents

Melissa R. Kinder, MD LLC
Hand and Reconstructive Surgery Northwest
10121 SE Sunnyside Rd. Ste. 235 Clackamas, OR 97015

By signing below, I agree that I have reviewed and understand the information presented and have been given a copy of the office procedures, policies, privacy practices and consents for Melissa R. Kinder, MD LLC, D.B.A. Hand and Reconstructive Surgery Northwest.

I understand that receipt of this paperwork does not establish patient physician relationship and does not direct any responsibility to Dr. Kinder or any entity of Hand and Reconstructive Surgery Northwest.

Patient Name (please print) _____

Patient signature: _____
(Patient sign if 18 years old or older)

Date _____

- OR -

Patient Representative Signature: _____

Description of Representative's Authority (Mother, Father, Guardian...) _____

Date _____