

ROBERT WAYNE, M.D., F.A.C.S.

2265 Exchange Street

Astoria, OR 97103

Phone: 503-325-9597

Fax: 503-338-4076

In order to expedite your first visit, please look over and complete the forms included with this letter before you arrive. Bringing these completed forms in for your appointment will decrease your waiting time and allow us to create your medical chart. If you have any questions about any of these forms, please feel free to call Connie at 503-338-4075, ext. 5729 or Adrienne at ext 5786.

**Please remember to bring these items to your first visit:**

- \* A list of medications and vitamins you are currently taking
- \* Insurance card and copayment if one is required
- \* If no insurance, a deposit of \$75 is required. We accept cash, check, Visa or Mastercard. If you are unable to bring this deposit, financial Arrangements can be made prior to your appointment.
- \* Photo I.D. (driver's license)

Thank you and we are looking forward to helping you to better health.

Sincerely,

Robert Wayne, MD and his staff

**\*\* Log on to: [www.robertwaynemd.com](http://www.robertwaynemd.com) for more information.**

# Dr. Robert Wayne Health History

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Reason for visit \_\_\_\_\_

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

Please list your Pharmacy \_\_\_\_\_

**Allergies:** Please list any allergies you may have including Latex, tape or metal or IVP Dye

Medication Name	Type or Reaction

Do you have problems with Anesthesia? No \_\_\_\_ Yes \_\_\_\_ describe: \_\_\_\_\_

**Medications:** Please list any medications you are taking on a regular basis including over the counter medications, vitamins, minerals and supplements.

Medication Name	Strength	Frequency	Reason for Taking

## Social History:

**Tobacco Use:** No \_\_\_\_ Yes \_\_\_\_ Current packs per day \_\_\_\_\_ Quit Date \_\_\_\_\_

**Caffeine Use:** No \_\_\_\_ Yes \_\_\_\_ Type and Frequency \_\_\_\_\_

**Alcohol Use:** No \_\_\_\_ Yes \_\_\_\_ Type and Frequency \_\_\_\_\_

**Drug Use:** No \_\_\_\_ Yes \_\_\_\_ Type and Frequency \_\_\_\_\_

**Fractures:** Please list any fractures below:

Type of Fracture	Location of Fracture

LAST COLONOSCOPY DATE \_\_\_\_\_

# Dr. Robert Wayne Health History

**Conditions: Check (✓) conditions you currently have or have had in the past**

<input type="checkbox"/> Aids	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes type _____	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Major Infection type: _____	<input type="checkbox"/> STD's
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Measles	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> MRSA	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Cancer type _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal Infections
	<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Other: _____

**Surgeries/Hospitalizations:** Please list surgeries or hospitalizations including pregnancies you've had below:

Year	Procedure/Reason for being Hospitalized	Outcome or Complications if any

**Family History:** Deceased      If Yes, Age      If No, Health History  
                          Yes      No      And from What:      Good      Fair      Poor

<b>Father:</b>						
<b>Mother:</b>						

**Please check (✓) any conditions that your blood relatives may have below:**

	Father:	Mother:	Brother:	Sister:
Arthritis				
Asthma				
COPD				
Bleeding problems				
Diabetes type 1				
Diabetes type 2				
Heart Disease				
High Blood Pressure				
Osteoporosis				
Kidney Disease				
Stroke				
Cancer Please list type:				
Other condition Please list:				

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**PATIENT INFORMATION REGISTRATION FORM**

**Date:**

**PATIENT INFORMATION**

Last Name		First Name		Middle Name
Birth/Maiden Name		Gender MALE      FEMALE	Social Security Number	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed			Date of Birth	
Race	<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian	<input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other	Ethnic group: <input type="checkbox"/> Hispanic-E1 <input type="checkbox"/> Non-Hispanic-E2 <input type="checkbox"/> Unknown-E9
Primary Language		Religion		Primary Provider
Address			City/State/Zip	
Home Phone		Cell Phone		Work Phone
E-mail Address			Referring Doctor (if different from Primary)	
Preferred Contact Method		<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone
Preferred Reminder Method		<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone
Driver's License Number		Driver's License Expiration Date		State

**EMPLOYMENT INFORMATION**

Employer Name and Address		Position
Is this a Workmen's Comp claim?	yes/no	If yes, Claim Number
Insurance handling claim		
Adjustor's Name		Adjustor's Contact Number

**SPOUSE/PARENT/GUARDIAN INFORMATION**

Spouse's Name		Social Security Number	Date of Birth
Guarantor Name (if patient is a minor)		Relationship to Patient	Date of Birth

**INSURANCE INFORMATION**

<b>Primary Insurance</b>	
Name of Policy Holder	Policy Holder Date of Birth
Policy Number	Group Number
Active Date	Relationship to Patient
<b>Secondary Insurance</b>	
Name of Policy Holder	Policy Holder Date of Birth
Policy Number	Group Number
Active Date	Relationship to Patient

**IN CASE OF EMERGENCY**

Name	Phone Number
Address	Relationship to patient

GENERAL SURGEON

**\*Please note: Your signature is required by law to allow us to bill your insurance.**

# HIPAA Notice of Privacy Practices

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Robert Wayne, M.D., F.A.C.S.  
2265 Exchange Street  
Astoria, OR 97103

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## 1. Uses and Disclosures of Protected Health Information

### Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_