

Please complete this form in blue or black ink

Denver Vail Orthopedics Patient Information

Patient ID: _____

Treating Physician: _____

Patient Name: _____

Preferred Name: _____ Sex: M F Marital Status: M S W D Partner

DOB: _____ Age: _____ S.S. # _____

Address: _____ City, St. Zip _____

Home #: _____ Cell #: _____ Email: _____

Employer: _____ Work # _____

Referring Provider: _____ Primary Care Provider: _____

Referring Prov. Ph# _____ Primary Care Prov. Ph# _____

Referring Prov. Add: _____ Primary Car Prov. Add: _____

Emergency Contact: _____ Relation _____ Phone# _____

Emergency Contact Address (If different):

Insurance Card(s) Given to Receptionist to be scanned. Yes No

PLEASE COMPLETE IF POLICY HOLDER IS DIFFERENT THAN PATIENT.

Primary Insurance Information: Please Complete

Policy Holder Name _____ Primary Ins _____

Policy Holder DOB: _____ Policy ID # _____

Policy Holder _____ Group # _____
(if different from PT)

Policy Holder SS # _____

Policy Holder Employer: _____

Denver Vail Orthopedics Patient Information Continued

*****Other Insurance Information: (Secondary, Work's Comp, or Auto) PLEASE CIRCLE*****

Policy Holder Name _____ Other Insurance _____

Policy Holder DOB _____ Policy ID # _____

Policy Holder Address _____
(If different from pt) _____ **Group #/W. Comp Claim #** _____

Policy Holder SS# _____ Adjustor _____
Phone: _____ Fax: _____

Policy Holder Employer _____

Assignment of Benefits: Please remember that insurance contracts are made between the patient and the Insurance company. Often the insurance does not provide full payments of medical costs. Payment of the bill is, therefore, your responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize payment of medical benefits to Denver Vail Orthopedics, PC for services of myself.

Date _____ Signed: X _____
"SIGNATURE ON FILE" will automatically print on your claim, allowing your insurance to pay us directly.

Records Release: I hereby authorize the release of any information, including medical and billing information, by Denver Vail Orthopedics, PC to my referring doctor or insurance company.

Date _____ Signed: X _____

Notice of Privacy: I have received a copy of the Notice of Privacy Practices from Denver Vail Orthopedics, PC

Date _____ Signed: X _____

DENVER VAIL ORTHOPEDICS

PATIENT: _____ Age: _____ DOB: _____ DATE: _____

REFERRING DOCTOR: _____ LANGUAGE _____ INTERPRETER? Y N: _____

OCCUPATION: _____ ARE YOU CURRENTLY WORKING? Y N

CHIEF COMPLAINT: _____ DATE OF INJURY/ONSET: _____ TYPE OF INJURY:
WORK AUTO OTHER

HISTORY OF PRESENT ILLNESS:
BRIEFLY EXPLAIN WHAT HAPPENED: _____

PRIOR INJURIES TO THE SAME AREA? Y N WHAT/WHEN? _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS:

DO YOU HAVE OR EVER HAD THE FOLLOWING:

HIGH BLOOD PRESSURE	Y OR N	GOUT	Y OR N
HEART DISEASE	Y OR N	CANCER	Y OR N
DIABETES	Y OR N	TYROID DISORDER	Y OR N
STROKE	Y OR N	HEPATITIS OR HIV	Y OR N
ULCERS/STOMACH PROBLEMS	Y OR N	HEART STENTS	Y OR N
ARTHRITIS	Y OR N	BLOOD CLOTS/BLEEDING DISORDER	Y OR N
RECENT WEIGHT LOSS	Y OR N	PSYCHIATRIC CONDITIONS	Y OR N
OTHER	Y OR N	(ANXIETY/DEPRESSION)	

IF YOU ANSWERED YES TO ANY OF THE ABOVE, BRIEFLY DESCRIBE: _____

PLEASE GIVE US YOUR PAST SURGICAL HISTORY:

1) _____ DATE: _____
2) _____ DATE: _____
3) _____ DATE: _____

FAMILY HISTORY: PLEASE INDICATE IF ANY FAMILY MEMBER HAS ANY OF THE FOLLOWING:

BLEEDING PROBLEMS _____ HEART ATTACKS _____ DIABETES _____ REACTION TO ANESTHESIA _____

MEDICATION THAT YOU ARE TAKING AT THIS TIME: (Please include over the counter and prescribed medications)

HERBAL SUPPLEMENT OR VITAMINS (name and dosage) _____

ALLERGIES TO MEDICATIONS OR LATEX: _____

DO YOU USE TABACCO PRODUCTS? Y OR N HOW MUCH? _____

HOW MUCH ALCOHOL DO YOU CONSUME IN A WEEK? _____

DO YOU PARTAKE IN RECREATIONAL DRUGS? Y OR N - MAY WE ASK WHAT KIND? _____

COULD YOU BE PREGNANT? Y OR N HT: _____ WT: _____