

Denver Vail Orthopedics Patient Information

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Patient ID: 1016

Please Complete Entire Form

Date: 5/26/2011

Time: 4:38 PM

Treating Physician: _____ **Name:** _____

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

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

Address: _____ **City, St., Zip** _____

Race: _____ Declined **Ethnicity:** _____ Declined **Primary Language:** _____ Declined

Home #: _____ **Cell #:** _____ **Email:** _____

Employer: _____ **Work #:** _____

Referring Provider: _____ **Primary Care Provider:** _____

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

Referring Prov Addr: _____ **Primary Care Prov. Addr:** _____

Emergency Contact: _____ **Relation:** _____ **Emg/ Contact 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:

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder (If different from Pt) _____
Policy Holder SS#: _____

Policy Holder Employer: _____

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

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder Address: _____
(If different from pt)
Policy Holder SS#: _____

Policy Holder Employer: _____

Please Complete:

Primary Ins: _____

Policy ID #: _____

Group # _____

Date of Injury: _____

Site of Injury: _____

Other Insurance: _____

Policy ID #: _____

Group #/ W. Comp. Claim # _____

Adjuster: _____

Phone #: _____ **Fax #:** _____

HOW WERE YOU REFERRED TO US? _____

Assnment of Benefits: Please remember that insurance contracts are made between the patient and the insurance company. Often the insurance does not provide full payment 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 to 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 and insurance company.

Date: _____ Signed: X _____

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

Date: _____ Signed: X _____

DENVER-VAIL ORTHOPEDICS, PC

MEDICAL HISTORY FORM

Please complete both sides and do not use white out

NAME _____ DOB _____ AGE _____ TODAY'S DATE _____

PREFERRED PHARMACY _____ PHARM. PHONE _____

PHARMACY ADDRESS _____ PHARM. FAX _____

PAST MEDICAL HISTORY:

NO MEDICAL PROBLEMS	Y/N HYPERTENSION (HBP)	Y/N THYROID DISORDER
Y/N BLOOD CLOT IN LEG (ACUTE/CHRONIC)	Y/N HEART ATTACK (MI)	Y/N WEIGHT LOSS
Y/N CVA (STROKE) WHEN? _____	Y/N OSTEOARTHRITIS	Y/N CANCER (TYPE _____)
Y/N COPD	Y/N OSTEOPOROSIS	_____
Y/N CORONARY ARTERY DISEASE	Y/N PEPTIC ULCER DISEASE	Y/N BLEEDING DISORDER (TYPE _____)
Y/N CROHN'S DISEASE	Y/N PERIPHERAL NEUROPATHY	_____
Y/N DEPRESSIVE DISORDER	Y/N PERIPHERAL VASCULAR DISEASE	Y/N CLOTTING DISORDER (TYPE _____)
Y/N DIABETES MELLITUS TYPE I	Y/N POLIO	_____
Y/N DIABETES NELLITUS TYPE II	Y/N PULMONARY EMBOLISM	
Y/N GOUT	Y/N REACTION TO ANESTHESIA	
Y/N HEPATITIS	Y/N RHEUMATIOD ARTHRITIS	
Y/N HIV	Y/N SYSTEMIC LUPUS	
Y/N OTHER _____		

HAVE YOU HAD ANY SURGERIES OR PROCEDURES? Y/N

SURGERY/PROCEDURE	YEAR
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL PRESCRIPTIONS, OVER-THE-COUNTER MEDICINES AND SUPPLEMENTS YOU TAKE REGUALRY

MEDICATION	DOSE/FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU HAVE ANY ALLERGIES TO MEDICATION OR LATEX? Y/N

ALLERGIC TO:	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

HAS ANY BLOOD RELATIVE HAD ANY OF THTE FOLLOWING? CHECK ALL THAT APPLY

<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> CHRONIC DVT OF LEG	<input type="checkbox"/> CANCER – TYPE _____
TYPE _____	<input type="checkbox"/> SUDDEN CARDIAC DEATH	<input type="checkbox"/> MUSCULAR DYSTROPHY
<input type="checkbox"/> CLOTTING DISORDER	<input type="checkbox"/> ARTHRITIS (OSTEO OR RHEUMATOID)	<input type="checkbox"/> PULMONARY EMBOLISM
TYPE _____	<input type="checkbox"/> CARDIOVASCULAR DISEASE	<input type="checkbox"/> REACTION TO ANESTHESIA
	<input type="checkbox"/> DIABETES (TYPE I OR TYPE II – CIRCLE)	<input type="checkbox"/> SCOLIOSIS

OTHER/DETAILS FOR ABOVE: _____

SOCIAL HISTORY

ARE YOU CURRENTLY WORKING? YES NO CURRENT OCCUPATION: _____
MARITAL STATUS (CIRCLE): SINGLE ENGAGED MARRIED DIVORCED SEPARATED WIDOWED I LIVE ALONE PARTNER
DO YO HAVE CHILDREN? YES- HOW MANY _____ NO
DO YOU SMOKE? YES – HOW MUCH PER DAY? _____ NEVER QUIT- WHEN? _____
DO YOU USE SMOKELESS TOBACCO? YES – HOW MUCH PER DAY? _____ NEVER QUIT- WHEN? _____
DO YOU DRINK ALCOHOL? YES – HOW MUCH & HOW OFTEN? _____ NEVER QUIT- WHEN? _____
DO YOU USE ILLEGAL DRUGS? YES – HOW MUCH & HOW OFTEN? _____ NEVER QUIT- WHEN? _____
PRESCRIPTION DRUG ABUSE HISTORY? YES/NO DRUG _____
DO YOU DRINK CAFFEINE? YES/NO – WHAT KIND & HOW OFTEN? _____
HOW MUCH EXERCISE DO YOU GET? SEDENTARY 1 TIME/WEEK 1-3 TIMES/WEEK 4 OR MOR ETIMES/WEEK
ACTIVE BUT NO FORMAL EXERCISE

HISTORY OF PRESENT ILLNESS

WHO REFERRED YOU TO US? _____
WHICH IS YOUR DOMINANT SIDE? (CIRCLE) RIGHT HANDED LEFT HANDED AMBIDEXTROUS
WHAT ARE YOU BEING SEEN FOR TODAY? _____ RIGHT LEFT BOTH
WHEN DID YOUR SYMPTOMS START? _____
HOW DID YOUR SYMPTONS BEGIN? GRADUALLY SUDDENLY SPECIFIC INJURY
IS THIS A WORKER’S COMPENSATION INJURY? YES NO IS THIS THE RESULT OF AN AUTOMOBILE ACCIDENT? YES NO
IS THERE AN ATTORNEY INVOLVED WITH THIS INJURY? YES NO
PLEASE EXPLAIN WHAT HAPPENED: _____

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION? (EX: PHYSICAL THERAPY, INJECTIONS, WHEN? FOR HOW LONG?)

TREATMENT TRIED	MONTH/YEAR	HOW MANY TIMES/WEEKS/MONTHS
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT TREATMENTS HELPED? _____

WHAT TESTS HAVE BEEN PERFORMED FOR THIS CONDITION?
X-RAY WHEN? _____ WHERE? _____
MRI WHEN? _____ WHERE? _____
CT WHEN? _____ WHERE? _____
EMG WHEN? _____ WHERE? _____

HAVE YOU INJURED THIS AREA BEFORE? YES NO DESCRIBE: _____

HAVE YOU MISSED TIME AT WORK FOR THIS CONDITION? YES NO COULD YOU BE PREGNANT YES NO

HEIGHT: _____ WEIGHT: _____

REVIEW OF SYSTEMS – DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS?

- | | | |
|--------------------------|--------------------------------|---------------------------------|
| Y/N FEVER/CHILLS | Y/N SHORTNESS OF BREATH | Y/N WEIGHT LOSS |
| Y/N BLURRY VISION | Y/N NAUSEA | Y/N ANXIETY |
| Y/N HEADACHE | Y/N INCONTINENCE | Y/N DEPRESSION |
| Y/N VERTIGO | Y/N RASH | Y/N BLOOD CLOTS/BRUISING |
| Y/N CHEST PAIN | Y/N MUSCLE WEAKNESS | Y/N FREQUENT ILLNESS |