ALPINE ORTHOPEDICS & SPORTS MEDICINE

Patient Intake Form

Patient Name:______________________ Age:________ Date:____________

What are we seeing you for today?______________________________________

Is the reason for your visit today injury related? ☐ Yes ☐ No Date of injury or onset of symptoms: ____________

Is this work related? ☐ Yes ☐ No Where did injury occur?____________________

Please briefly describe your problem/the injury:______________________________________

____

Have you been evaluated for this problem by another provider, physical therapist, chiropractor, acupuncturist, etc.? ☐ Yes ☐ No

If yes, by whom and approximately when?______________________________________

Have you had previous imaging or testing for this problem? ☐ Yes ☐ No Please circle type: X-rays MRI CT Nerve Tests

If yes, when and where were the studies performed?______________________________________

Have you had prior injections surgeries for this problem? ☐ Yes ☐ No

If yes, when and where? ______________________________

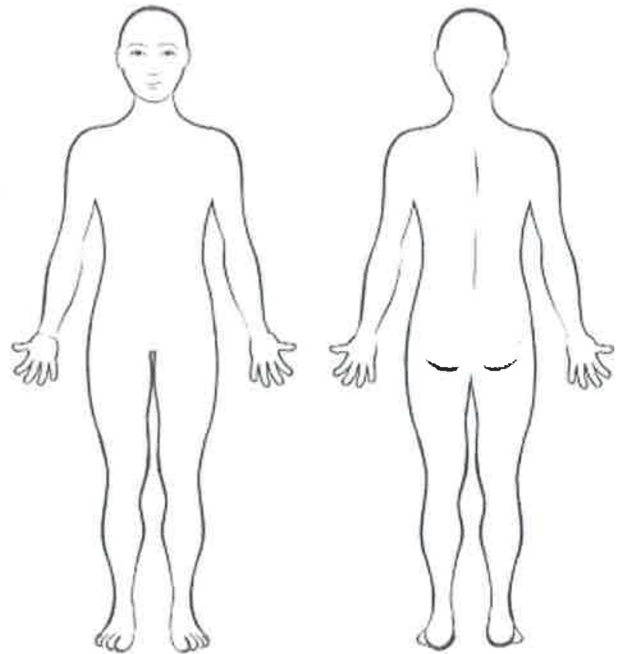
Please indicate your symptoms on the model using the following symbols:

(+) Ache

(O) Numbness

(*) Pins/Needles

(///) Sharp/Stabbing



On a scale of 0-10 with 10 being the worst imaginable pain, please rate your current pain:____________________

Is this problem causing difficulty with your sleep?

☐ Yes ☐ No

Are you taking any pain medications? ☐ Yes ☐ No

If yes, please list:______________________________

Please check the symptoms that apply. Then list the area of your body where you are experiencing the symptom.

☐ Swelling:______________ ☐ Popping or clicking:______________ ☐ Instability:______________

☐ Locking:______________ ☐ Stiffness:______________ ☐ Pain at night:______________

☐ Numbness/tingling:______________ ☐ Weakness:______________ ☐ Other: ______________

Any change in bowel or bladder function? ☐ Yes ☐ No

Does anything improve your symptoms?______________________________________

Does anything make your symptoms worse?______________________________________

How far can you walk without stopping? ______________________________________

Are there any activities that your symptoms prevent you from doing?______________________________________

____

____

Alpine Orthopedics & Sports Medicine
536 Cottonwood, Ste 100
Bozeman, MT 59718
406-586-8029

PATIENT INFORMATION

Print Name: ______________________ Sex: ☐ Male ☐ Female
Mailing Address: ______________________ Date of Birth: ______________________
City, State, Zip: ______________________ Social Security #: ______________________
Physical Address: ______________________ Marital Status: ☐ Married ☐ Single ☐ Divorced
City, State, Zip: ______________________ Email Address: ______________________
Home Phone: ____________ Work: ____________ Who Referred You: ______________________
Cell/ Pager Phone: ______________________ Primary Physician: ______________________
Preferred method for appointment reminders ☐ Phone ☐ Email ☐ Text

PATIENT EMPLOYMENT INFORMATION

Employed ☐ Retired ☐ Unemployed ☐ Other
Employer's Name: ______________________
Employer's Phone: ______________________
Occupation: ______________________

EMERGENCY CONTACT

Name: ______________________
Relationship: ______________________
Phone: ______________________

RESPONSIBLE PARTY (If Patient is Under 18 Years of Age)

Name: ______________________ Employer: ______________________
Address: ______________________ Date of Birth: ______________________
City, State, Zip: ______________________ Social Security # : ______________________
Home Phone: ______________________ Cell Phone: ______________________
Work Phone:

PRIMARY INSURANCE

Insurance Company Name: ______________________
ID #: ______________________ Group/Policy #: ______________________
Subscriber's Name: ______________________ Relationship to Patient: ______________________
Subscriber's Social Security # : ______________________ Subscriber's Date of Birth: ______________________
Subscriber's Phone #: ______________________ Subscriber's Employer: ______________________

WORKER'S COMPENSATION OR ACCIDENT RELATED INJURY

Compensation Provider Name: ______________________ Adjuster's Name: ______________________
Address: ______________________ Phone #: ______________________
City, State, Zip: ______________________ Fax #: ______________________
Claim #: ______________________ Date of Injury: ______________________
Employer at Time of Injury: ______________________

PATIENT DEMOGRAPHIC INFORMATION

☐ **Prefer not to share this information**

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ White ☐ Other Race ☐ Unknown
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown
Principle Language: ☐ English ☐ Arabic ☐ Chinese ☐ French ☐ German ☐ Italaian ☐ Japanese ☐ Spanish ☐ Vietnamese

YOUR MEDICAL RECORDS WILL BE RETAINED FOR NO LONGER THAN 7 YEARS
ALPINE ORTHOPEDICS & SPORTS MEDICINE COMPLIES WITH APPLICABLE FEDERAL CIVIL RIGHTS LAWS AND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY OR SEX.

SIGNATURE of Responsible Party ______________________ **Relationship** ____________ **Date** ____________

Patient Medical Profile

Patient Name : ______________________ Age: ____
Who may we thank for referring you to us? ______________
Primary care physician (if different): ______________
Reason for visit: ______________
Date of injury / Onset of problem: ______________

CURRENT HEALTH

Please list any medical problems you have or have been diagnosed with: ☐ No problems

Height: ______
Weight: ______

☐ Heart disease or attack
☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Asthma
☐ COPD / Emphysema

☐ Stroke
☐ Cancer
☐ Thyroid problems
☐ Kidney disease
☐ Blood Clot
☐ Chronic headaches

☐ Heartburn / Reflux
☐ Stomach ulcers
☐ Gout
☐ Rheumatoid arthritis
☐ Sleep Apnea
☐ Depression

Please list other medical problems:

____
____
____
____

Females Only: Date of last menstrual period: ______ Currently Pregnant? ☐ Yes ☐ No ☐ Possibly

SURGICAL HISTORY

Please list all previous surgeries and the approximate year: ☐ I have not had any surgeries

Surgery:	Year:	Surgery:	Year:

Do you have allergies or any problems with anesthesia? ☐ No ☐ Yes Describe: ______________

MEDICATIONS

Please list any medication you currently use, including over-the-counter medications, vitamins, and supplements::

____
____
____
____
______________ ☐ I take no medications

ALLERGIES AND REACTION

☐ No Known Drug Allergies
☐ Penicillin
☐ Sulfa Drugs
☐ Iodine
☐ Diagnostic Dyes
☐ Latex
☐ Adhesive Tape

☐ Other: ______ **REACTION:** ______________

FAMILY HISTORY

Does anyone in your immediate family (parents, brothers, sisters, children) have any of the following:

☐ Diabetes
☐ Heart Disease
☐ Asthma
☐ Blood Clots

☐ Gout
☐ Lupus
☐ Rheumatoid Arthritis
☐ Osteoarthritis

☐ Hip Problems
☐ Back Disc Problems
☐ Ankylosing Spondylitis
☐ Psoriasis

☐ Osteoporosis
☐ Cancer
☐ Other: ______

SOCIAL HISTORY

Current / Past Occupation: ____________ ☐ I am Disabled Reason: ____________

Who lives with you? ____________ ☐ I live alone

Do you drink alcohol? ☐ No ☐ Yes How Often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

Do you smoke? ☐ No ☐ I quit in ______ (year) ☐ Yes Number of packs daily: ____________

Do you use any other substances? ☐ Smokeless tobacco ☐ Recreational drugs Please list: ____________

REVIEW OF SYSTEMS

Please circle any that apply to you:

General	Fevers	Chills	Night sweats	Fatigue	Loss of appetite	Weight loss	Weight gain
Eyes	Blurred vision	Eye pain	Glasses / Contacts				
Ear, Nose, Throat	Hearing loss	Mouth sores	Voice changes	Frequent nose bleeds			
Cardiovascular	Heart attack	Chest pain	Palpitations	Leg swelling	Heart murmur		
Respiratory	Sleep apnea	Wheezing	Chronic cough	Tuberculosis			
Gastrointestinal	Frequent diarrhea	Heartburn	Constipation	Nausea / Vomiting	Blood in stool		
Genitourinary	Kidney stones	Incontinence	Frequent urination	Painful urination	Blood in urine		
Musculoskeletal	Joint swelling	Back pain	Trouble walking	Weakness			
Skin	Color change	Rash	Cellulitis	Psoriasis			
Neurologic	Headaches	Dizziness	Bad balance	Numbness / Tingling			
Hematologic	Enlarged glands	Anemia	Bleeding disorders				
Psychological	Depression	Anxiety	Trouble sleeping	Memory loss			
Other (please list):							

MISCELLANEOUS INFORMATION

Please list any more information that may be important to your visit today.

____

____

SIGNATURE

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

____________ Signature of patient (parent or guardian if the patient is a minor) ____________ Date

Reviewed and updated by PHYSICIAN:

Initials	Initials	Initials	Initials	Initials	Initials	Initials
Date	Date	Date	Date	Date	Date	Date

Reviewed and updated by PATIENT:

Initials	Initials	Initials	Initials	Initials	Initials	Initials
Date	Date	Date	Date	Date	Date	Date

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Financial Policy

We will bill your primary insurance company as a courtesy to you. We will also bill your supplementary insurance if it is provided to us. **It is your responsibility to verify coverage and/or pre-authorization of any services, supplies or procedures prior to services by our staff.**

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account regardless of insurance coverage or other third party involvement. I hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services

I am aware that my insurance carrier may consider some services and/or supplies "non-covered", therefore I will become fully responsible for the payment of theses charges.

Assistant Surgeon Charges

I am aware that should I have a surgical procedure, my doctor may require the assistance of a qualified assistant surgeon, P.A or surgical RN. The assistant fee is 20% of the surgeon's fee per procedure. I am aware that I am responsible for theses charges if not covered by my insurance.

Insurance Assignment and Release of Information

I hereby assign benefits to be paid directly to Alpine Orthopedics and Sports Medicine. I hereby authorize Alpine Orthopedics and Sports Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that my account becomes past due, I understand that I agree to pay all collection costs, attorney costs and court costs necessary to collect payment. I have read all of the above and understand/agree to all the provisions therein regarding my financial responsibility and release of information.

PRINT Patient's Name: ______________________________ Date: ______________

Patient or Legal Guardian's Signature: ______________________________

If Legal Guardian, Relationship to Patient: ______________________________

Privacy Practice Record

I have received the Alpine Orthopedics and Sports Medicine notice of Privacy and Practice Standards of Protected Health Information.

I authorize Alpine Orthopedics and Sports Medicine to request and review my records from any entity in which my provider is affiliated.

I authorize Alpine Orthopedics and Sports Medicine and The Orthopedic Surgical Center of Montana to send me information, which may include privileged health information, via email or texts. I acknowledge that I can request to be removed from these types of communication at any time.

Signature: ____ Date:________________

I authorize my provider and those acting on their behalf to release any medical information regarding my treatment in this practice in accordance with the HIPAA notice I have been provided, and further, to:

Name:________________________________Relationship:______________Date:_________

Name:________________________________Relationship:______________Date:_________

Name:________________________________Relationship:______________Date:_________