



# Patient Intake Form

Patient Name: \_\_\_\_\_

What are we seeing you for today? \_\_\_\_\_ Are you right or left handed (circle one)

What is your occupation? \_\_\_\_\_ Is this work related?  Yes  No

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

Where did the injury occur? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

If yes, by whom and for how long? \_\_\_\_\_ Have you had previous imaging studies?  Yes  No

Please circle and list the date and facility: X-rays MRI CT \_\_\_\_\_

Have you had injections or prior surgeries for this problem?  Yes  No Date and description: \_\_\_\_\_

Have you injured this same body part before?  Yes  No If yes, please describe: \_\_\_\_\_

Please describe the pain. (Example: sharp, dull, throbbing, aching, burning, etc.) \_\_\_\_\_

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 medication?  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: \_\_\_\_\_

Does anything improve your symptoms? \_\_\_\_\_

Does anything make your symptoms worse? \_\_\_\_\_

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  Italian  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 \_\_\_\_\_



**ALPINE**  
**ORTHOPEDICS**  
**& SPORTS MEDICINE**

# 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: \_\_\_\_\_

<input type="checkbox"/> Heart disease or attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heartburn / Reflux	Please list other medical problems: _____ _____ _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stomach ulcers	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Gout	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Sleep Apnea	
<input type="checkbox"/> COPD / Emphysema	<input type="checkbox"/> Chronic headaches	<input type="checkbox"/> Depression	

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       Iodine       Latex  
 Sulfa Drugs       Diagnostic Dyes       Adhesive Tape

Other: \_\_\_\_\_ REACTION: \_\_\_\_\_

## FAMILY HISTORY

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

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Hip Problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lupus	<input type="checkbox"/> Back Disc Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Psoriasis	

## 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:

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

## 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 \_\_\_\_\_ Date \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

Reviewed and updated by PATIENT:

Initials \_\_\_\_\_ Date \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

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: \_\_\_\_\_

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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 these 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 these 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, for all dates of service past, present and future. 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: \_\_\_\_\_