Patient Intake Form

Name ______________________________ Date of Birth ______________________

Location: ☐ Right Lower Extremity ☐ Left Lower Extremity

☐ Both – which side is pain worse R or L or Equal

Work injury: ☐ No ☐ Yes DOI: ____________ Prior Surgery: ____________________

What are your favorite activities or sports: ____

Describe your problems: ____

How long has it bothered you? ____

How did symptoms begin? ____

Medications used for foot and ankle pain? ____________________________________

Is your problem getting: ☐ Better ☐ Worse ☐ Same

Describe symptoms (circle all that apply)

Rate Discomfort: None = 1 2 3 4 5 6 7 8 9 10 = Severe

Location: Medial (Inner) Lateral (Outer) Plantar (Bottom) Dorsal (Top)

Other: ____

Quality: Sharp Dull Tingling Electric Shock Constant Intermittent

Other: ____

Associated Symptoms:

Stiffness Where? ______________________________________

Numbness Where? ______________________________________

Swelling Where? ______________________________________

Catching Where? ______________________________________

Weakness Where? ______________________________________

Gives Out Where? ______________________________________

When do symptoms occur? ☐ Morning ☐ Night ☐ Work ☐ Sports ☐ Running

☐ During Activity ☐ After Activity ☐ Constant ☐ Occasional

☐ Other ____

What makes the symptoms better? ☐ Rest ☐ Therapy ☐ Brace/Splint ☐ Exercise

☐ Heat ☐ Cold ☐ Other: ______________________________

Pain in other joints? ☐ No ☐ Yes, List: ______________________________________

Previous tests? ☐ No ☐ Yes, Describe: ______________________________________

Previous Treatments? ☐ No ☐ Yes, Describe: ______________________________________

Do you smoke? ☐ No ☐ Yes

Do you have Diabetes? ☐ No ☐ Yes

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

PATIENT INFORMATION

Print Name: ______________________________
Mailing Address: ______________________________
City, State, Zip: ______________________________
Physical Address: ______________________________
City, State, Zip: ______________________________
Home Phone: ________________ Work: ________________
Cell/ Pager Phone: ______________________________
Preferred method for appointment reminders ☐ Phone ☐ Email ☐ Text

Sex: ☐ Male ☐ Female
Date of Birth: ______________________________
Social Security #: ______________________________
Marital Status: ☐ Married ☐ Single ☐ Divorced
Email Address: ______________________________
Who Referred You: ______________________________
Primary Physician: ______________________________

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: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Home Phone: ______________________________
Work Phone:

Employer: ______________________________
Date of Birth: ______________________________
Social Security # : ______________________________
Cell Phone: ______________________________

PRIMARY INSURANCE

Insurance Company Name: ______________________________
ID #: ______________________________
Subscriber's Name: ______________________________
Subscriber's Social Security # : ______________________________
Subscriber's Phone #: ______________________________

Group/Policy #: ______________________________
Relationship to Patient: ______________________________
Subscriber's Date of Birth: ______________________________
Subscriber's Employer: ______________________________

WORKER'S COMPENSATION OR ACCIDENT RELATED INJURY

Compensation Provider Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Claim #: ______________________________

Adjuster's Name: ______________________________
Phone #: ______________________________
Fax #: ______________________________
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

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 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, 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: ____________________________________