Patient Intake Form

ALPINE
ORTHOPEDICS & SPORTS MEDICINE

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 ☐ 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** _____

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& 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: _____

- ☐ 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 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.

No Show Policy

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This will give our office time to try and fill that appointment spot. Failure to notify our office will lead to your appointment being no showed. If three no-shows occur, the patient may be dismissed from Alpine Orthopedics.

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: _____

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:_____