Denver Vail Orthopedics Patient Information

Patient ID:

Please Complete Entire Form

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 #:** _____

Preferred Communications _____

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

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

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? _____

Assginment 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, P.C.
Medical History Form

NAME: _____ DOB: _____ (AGE _____) TODAY'S DATE: _____

PREFERRED PHARMACY: _____ PHARMACY PHONE: _____

PHARMACY ADDRESS: _____ PHARMACY FAX: _____

PAST MEDICAL HISTORY

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

HAVE YOU HAD ANY SURGERIES OR PROCEDURES? Y/N

Surgery/Procedures	Date/Year

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

Medication	Dose/Frequency **Required**

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

(PLEASE COMPLETE BOTH SIDES)

NAME: _____ DOB: _____ TODAY'S DATE: _____

HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING AND INDICATE FAMILY MEMBER? CHECK ALL THAT APPLY. M =MOTHER F=FATHER S=SISTER B=BROTHER D=DAUGHTER SON=SON

☐	BLEEDING DISORDER- TYPE _____	☐	CHRONIC DVT OF LEG	☐	CANCER- TYPE _____
☐	CLOTTING DISORDER- TYPE _____	☐	SUDDEN CARDIAC DEATH	☐	MUSCULAR DYSTROPHY
☐	OTHER _____ _____	☐	ARTHRITIS (OSTEO OR RHEUMATOID)	☐	PULMONARY EMBOLISM
		☐	CARDIOVASCULAR DISEASE	☐	REACTION TO ANESTHESIA
		☐	DIABETES TYPE I OR TYPE II (CIRCLE)	☐	SCOLIOSIS

REVIEW OF SYSTEMS

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, BLEEDING
Y/N CHEST PAIN	**Y/N** MUSCLE WEAKNESS	**Y/N** FREQUENT ILLNESS

SOCIAL HISTORY

ARE YOU CURRENTLY EMPLOYED? YES NO CURRENT OCCUPATION: _____

MARITAL STATUS (CIRCLE):
SINGLE ENGAGED MARRIED DIVORCED SEPARATED WIDOWED I LIVE ALONE PARTNER

DO YOU 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 MORE TIMES/WEEK
ACTIVE BUT NO FORMAL EXERCISE

HISTORY OF PRESENT ILLNESS

WHO REFERRED YOU TO US? _____

WHAT ARE YOU BEING SEEN FOR TODAY? _____ RIGHT LEFT BOTH

WHEN DID YOUR SYMPTOMS START/ DATE OF INJURY? _____

IF THERE IS NOT A SPECIFIC DATE, HOW LONG HAVE YOU HAD SYMPTOMS? _____

WHAT ARE YOUR SYMPTOMS? _____

LEVEL OF PAIN 1-10 (CIRCLE ONE):

(1/2 MILD) (3/4 MILD TO MODERATE) (5/6 MODERATE) (7/8 MODERATE TO SEVERE) (9/10 SEVERE)

INTERMITTANT OR CONSTANT?_____

WHAT ACTIVITIES MAKE YOUR SYMPTOMS WORSE? _____

DESCRIBE PROBLEM/ INJURY/ ACCIDENT IN DETAIL? _____

_____

_____

_____

_____

_____

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

_____

WEIGHT: _____ HEIGHT: _____

COULD YOU BE PREGNANT? YES NO

WHICH IS YOUR DOMINANT SIDE? (CIRCLE) RIGHT LEFT AMBIDEXTROUS

OFFICE USE- BP: _____ TEMPERATURE: _____ PULSE: _____

NAME: _____ DOB: _____ TODAY'S DATE: _____

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

IS THIS A WORKER'S COMPENSATION INJURY? YES NO

IS THIS INJURY THE RESULT OF AN AUTOMOBILE ACCIDENT? YES NO

IS THERE AN ATTORNEY INVOLVED WITH THIS INJURY? YES NO

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 IMPROVE YOUR SYMPTOMS?_____

WHAT TESTS HAVE BEEN PERFORMED FOR THIS CONDITION?

X-RAY WHEN? _____ WHERE? _____

MRI WHEN? _____ WHERE? _____

CT WHEN? _____ WHERE? _____

EMG WHEN? _____ WHERE? _____

OTHER WHEN? _____ WHERE? _____

OTHER WHEN? _____ WHERE? _____