

Name:
DOB:
Acct #:
Age:
Date:



Patient Registration

Section I	Patient Information	Date
Last Name: _____ First: _____ M.I. _____ I prefer to be called: _____		
Mailing Address: _____ City: _____ State: _____ Zip _____		
Home Phone _____ Cell Phone _____ Work Phone _____		
Email: _____ Employer: _____		
Date of Birth: _____ Social Security Number: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Race: _____ Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other Language: <input type="checkbox"/> English <input type="checkbox"/> _____ (Language)		
Emergency Contact: _____ Phone: _____		
Relationship of Emergency Contact: _____		

Section II Insurance Information- **Complete if you did not provide your current insurance card(s)
Name of Insured _____ DOB _____ Relationship to Patient _____
Policy Holder ID or SSN: _____ Insurance Company _____
DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING _____
Insurance Company _____ DOB _____ Relationship to Patient _____

HIPAA Privacy Practices:
**By law we can only speak to you about your treatment. If you'd like us to be able to speak with someone other than you please provide the name(s) on this form. By doing so, you authorize OSS to speak with such individual(s).
Authorized Contact(s): _____
Initial Below: Acknowledgment, Receipt, and Notice of HIPAA Privacy Practices: I understand OSS has posted their HIPAA Privacy Practices notifying me of the uses and disclosures of my Personal Health Information and also informing me of my rights to access and control my Personal Health Information. I understand a copy will be provided to me upon request.

Prescription Medication History and Electronic Prescribing:
Initial Below: I understand and agree that OSS may request and use my prescription history from other healthcare providers for treatment purposes.

** By signing this form, I authorize payments of any insurance benefits for health care services be made directly to Orthopaedics of Steamboat Springs. Note: If patient is a minor, this form must be signed by a parent or legal guardian. I understand that I am responsible for any portion of fees not paid by an insurance company or other coverage plan.

Patient or Legal Guardian Signature _____ Date _____
Patient or Legal Guardian Signature _____ Date _____ FC2

Name:
DOB:
Chart:
Age:
Date:



Steamboat Spine Center Patient Intake Form

Patient Information

Patient's Full Name _____ Date _____ Male Female
Date of Birth _____ Age _____ Height: _____ Weight: _____
Employer: _____ Years employed with current employer _____

Health Information

Past Medical History:

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease/Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastritis/Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	GERD (Reflux)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma/Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	-When: _____ Where: _____	
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____	Chemo/Radiation: <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____

Past Surgical History:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Drug Allergies:

None Known
_____ Reaction: _____
_____ Reaction: _____
Iodine/Contrast Reaction Yes No

Social History:

Marital Status: Single Married Widowed
Kids: Yes No How many? _____
Have you ever smoked? Yes No
Date began: _____ Date Quit: _____
Amount/packs per day: _____
Alcohol Yes No Amount: _____
Past or present alcohol and/or drug dependency?
 Yes No Type: _____

Family History:

Spinal Problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Bleeding Disorders	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Autoimmune Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling

Employment History:

Working Retired Disabled - When: _____
Job Description: _____

Medications, Vitamins, & Supplements (Or provide a current list):

List all medications you are currently taking

- _____ Dosage: _____ Frequency: _____
- _____ Dosage: _____ Frequency: _____
- _____ Dosage: _____ Frequency: _____
- _____ Dosage: _____ Frequency: _____
- _____ Dosage: _____ Frequency: _____

Name:
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Spine Center Patient Intake Form Cont.

Review of Symptoms:

Numbness or tingling in arms or legs Yes No
Bowel or bladder Incontinence: Yes No
Weakness in arms or legs: Yes No

Describe: _____
Describe: _____
Describe: _____

Constitutional

Fever/Chills Yes No
Loss of appetite Yes No
Weight Loss/Gain Yes No

Psychiatric

Anxiety Yes No
Poor sleep Yes No
Depression Yes No

Allergy/Immune

Iodine/Contrast allergy Yes No
Seasonal allergy Yes No
Food allergy Yes No

Skin/Integumentary

Ulcer Yes No
Rash/Hives Yes No
Eczema Yes No
Psoriasis Yes No

Musculoskeletal

Joint pain/swelling Yes No
Muscle pain/swelling Yes No
Pain w/ exercise Yes No
Muscle tears Yes No

Respiratory / CV

Shortness of breath Yes No
Cough/Wheezing Yes No
Chest pains Yes No
Palpitations Yes No
Leg/foot swelling Yes No

Endocrine

Obesity Yes No
Diabetes Yes No
Thyroid disease Yes No
Fatigue Yes No

Gastrointestinal

Loss of bowel control Yes No
Nausea/vomiting Yes No
Diarrhea Yes No
Constipation Yes No

Neurologic

Headaches Yes No
Numbness Yes No
Weakness Yes No
Balance issues Yes No

Ears, Eyes, Nose, Throat

Decreased vision Yes No
Decreased hearing Yes No
Sinus problems Yes No

Hemolympathic

Anemia Yes No
Excessive bruising Yes No
Lymph node swelling Yes No
Bleeding problems Yes No

Genitourinary

Loss of urine control Yes No
Sexual difficulties Yes No
Pregnant Yes No
Difficulty urinating Yes No

Patient/Guardian Signature _____ Date: _____

Patient/Guardian Signature _____ Review Date: _____

Patient/Guardian Signature _____ Review Date: _____

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Steamboat Orthopaedic and Spine Treatment Agreement

Patient's Billing Agreement:

- I understand payment is due at the time of service. This includes any deductible, copayment, and coinsurance amounts.
- I authorize the release of my medical information to my insurance company and I authorize payment from my insurance company be made directly to Orthopaedics of Steamboat Springs (OSS).
- I authorize SOSI personnel to provide medical treatment.
- I understand that I am responsible for any portion of fees or services not covered by my insurance company/other payer (non-contracted insurance plans) or services that are not a covered benefit (contracted).
- I also understand that I am responsible in full for all fees if I have provided inaccurate insurance/payer information.
- I understand that if my account becomes past due, Orthopaedics of Steamboat Springs will take the necessary steps to collect this debt and this may include collection of associated collection company fees and/or legal fees.
- I understand that my insurance is a contract between myself and my insurance company and that I am personally responsible for all expenses accrued during evaluation and treatment at SOSI.
- I understand that as a courtesy my insurance/third party payer will be billed (for non-contracted insurance companies) however, it is my responsibility to follow up on delinquent claims.
- If I do not have insurance, I understand that I am responsible for payment at the time of service.
- I understand I have the right to request a copy of my medical records from SOSI and I understand there may be a charge for obtaining these records.
- I authorize the facility, Steamboat Orthopaedic and Spine, or any other collection or servicing agency retained by the facility (together referred to hereafter as "collectors"), to collect any money that I owe to the facility. I agree that I may be contacted by phone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.
- I understand I may be contacted by voice, text, or email as part of the patient experience.

Treatment of Minor Patients:

- For all services rendered to minor patients, we will look to the adult accompanying the patient and/or the parent/guardian with custody for payment or payment may be arranged prior to the appointment.
- _____ Parent or Legal Guardian: Initial here if you give consent and agree to have your child treated without you or another parent or legal guardian present.

Patient/Guardian Signature

Date