Name:
DOB:
Acct #:
Age:
Date:

STEAMBOAT ORTHOPAEDIC & SPINE INSTITUTE

SRSINT 1-9

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: _____ ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Other **Language:** ☐ English ☐ _____ (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?** ☐ **Yes** ☐ **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:
Acct #:
Age:
Date:

STEAMBOAT ORTHOPAEDIC & SPINE INSTITUTE

SRSINT 1-18

New Problem Intake

Patient Information

First and Last Name: _____ **Preferred Name:** _____ **Occupation:** _____

Age: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

How were you referred to our office? ☐ **Emergency Room** ☐ **Physician** _____ ☐ **Other** _____

Who is your primary care physician? _____ **Do you want notes sent to your PCP?** **Y** **N**

New Problem Information

What is the primary orthopaedic concern you are here for today? (circle)

Shoulder	Knee	Back	Foot
Elbow	Neck	Hand	Ankle
Hip	Arm	Wrist	Other_____

Which side(s)? Right Left Both

How did your injury occur?

☐ No Injury - just started hurting
☐ Sports (which sport)_____
☐ Motor Vehicle Accident
☐ Work
☐ Other_____
Do you have a work comp claim? ☐ Yes ☐ No

Date of Injury: _____

Describe your injury: _____

_____

_____

List any previous surgeries you've had for this problem.

_____ Date _____

_____ Date _____

Problems: (check all that apply)

☐ Pain
☐ Weakness
☐ Instability/giving way/ dislocation
☐ Stiffness
☐ Swelling
☐ Other_____

How long have you had these symptoms?

_____ Days _____ Months _____ Years

Rank the severity of your pain.
(0= none, 10 severe pain)
At rest: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

List any previous treatments for this problem.

_____

_____

_____

List any imaging studies you've had for this problem.

☐ X-ray Date:_____ Location_____
☐ MRI Date:_____ Location_____
☐ CT Scan Date:_____ Location_____
☐ Other Date:_____ Location_____

Patient/Guardian Signature _____ **Date** _____

Name:
DOB:
Acct #:
Age:
Date:

STEAMBOAT ORTHOPAEDIC & SPINE INSTITUTE

SRSINT 1-18

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:

Have you had any medical problems? ☐ Yes ☐ No

High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Gastritis/Ulcers	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Other	☐ Yes	☐ No _____

Past Surgical History:

Please list any surgeries you've had.

_____ Date _____
_____ Date _____
_____ Date _____

Social History:

Former tobacco user: ☐ No ☐ Yes(smoker) ☐ Yes(other)
Date Began Smoking: _____ Date Quit Smoking: _____
Current Tobacco Use: ☐ Yes ☐ No Packs per day _____
Alcohol ☐ Yes ☐ No Amount _____
Past or present chemical dependency ☐ Yes ☐ No

Medications, Vitamins, and Supplements:

List all medications you are currently taking. ☐ **None**

- _____
  Dosage _____ **Frequency** _____
- _____
  Dosage _____ **Frequency** _____
- _____
  Dosage _____ **Frequency** _____
- _____
  Dosage _____ **Frequency** _____

Allergies:

List all drugs to which you are allergic. ☐ **None Known**

- _____ Reaction _____
- _____ Reaction _____
- _____ Reaction _____

Family History:

Has anyone in your family had any of these conditions?

Stroke	☐ Yes	☐ No	Mother	Father	Sibling
Heart Disease	☐ Yes	☐ No	Mother	Father	Sibling
Cancer	☐ Yes	☐ No	Mother	Father	Sibling
Other	☐ Yes	☐ No	_____		

Hobbies: _____

Review of Systems:

Constitutional/General:			Cataracts	☐ Yes	☐ No	Foods	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No	**Gastrointestinal:**			Adhesive, dye, iodine	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Stomach Pain	☐ Yes	☐ No	**Musculoskeletal:**		
Cardiovascular:			Diarrhea	☐ Yes	☐ No	Joint Swelling	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Persistent Vomiting	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No	**Hematological:**			Muscle Aches	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No	**Endocrine:**		
Neurological:			Blood Transfusion	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No	History of Blood Clots	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	**Psychiatric:**			Other		
Respiratory:			Bipolar Disease	☐ Yes	☐ No	**Skin:**		
Shortness of breath	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	**Ears, Nose, Throat:**			Dryness of skin	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No	Loss of hearing	☐ Yes	☐ No	**Genitourinary:**		
Eyes:			Sinus problems	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No
Decreased Vision	☐ Yes	☐ No	**Allergies:**			Pain with urination	☐ Yes	☐ No

Patient/Guardian Signature: _____ **Date:** _____

Reviewed by: _____ **Initials** _____ **Date** _____

Reviewed by: _____ **Initials** _____ **Date** _____

Name:
DOB:
Acct #:
Age:
Date:

STEAMBOAT ORTHOPAEDIC & SPINE INSTITUTE

SRSINT1-9

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 inform
- 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 co 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