Name:
DOB:
Acct #:
Age:
Date:

STEAMBOAT Spine CENTER

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 _____

Name of Employer: _____ 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:
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	☐ Yes ☐ No	Kidney Disease/Stones	☐ Yes ☐ No
Heart Disease/Heart Attack	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Gastritis/Ulcers	☐ Yes ☐ No	GERD (Reflux)	☐ Yes ☐ No
Asthma/Emphysema	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Hepatitis/Liver Disease	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Bleeding problems	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	-When: _____	Where: _____

Cancer ☐ Yes ☐ No Type: _____ Chemo/Radiation: ☐ Yes ☐ 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	☐ Mother	☐ Father	☐ Sibling
Bleeding Disorders	☐ Mother	☐ Father	☐ Sibling
Heart Disease	☐ Mother	☐ Father	☐ Sibling
Cancer	☐ Mother	☐ Father	☐ Sibling
Diabetes	☐ Mother	☐ Father	☐ Sibling
Autoimmune Disease	☐ Mother	☐ Father	☐ Sibling
High Blood Pressure	☐ Mother	☐ Father	☐ 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:
DOB:
Chart:
Age:
Date:

Spine Center Patient Intake Form Cont.

Review of Symptoms:

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

Hemolymphatic

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: _____

Name:
DOB:
Chart:
Age:
Date:

Steamboat Spine Center 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**

Where is your pain located? _____

How long have you had this problem? _____Days _____ Months _____ Years

Does your pain radiate to a limb(arms or legs)? ☐ Yes ☐ No

Do you have numbness? ☐ Yes ☐ No Do you have weakness? ☐ Yes ☐ No

Rank the severity of your pain: Did symptoms follow an injury: ☐ Yes ☐ No

(0 = none, 10 Severe pain) Date of Injury: _____

At best: 0 1 2 3 4 5 6 7 8 9 10 If Yes: ☐ At work ☐ Auto Accident

At its worst: 0 1 2 3 4 5 6 7 8 9 10 ☐ Other, please describe: _____

Have you ever had these symptoms before? If yes, describe: _____

What makes symptoms better? _____

What makes symptoms worse? _____

Previous Treatments: Indicate previous treatment received and the results

Treatment	NO HELP	SOME RELIEF	MUCH RELIEF
Physical Therapy/Exercise: When:_____ Where:_____			
Injections: Type: ☐ Trigger Point ☐ Epidural ☐ Joint ☐ Nerve Block ☐ Other: _____ When:_____			
Muscle Relaxants			
Pain Killers			
Anti-inflammatories			
Hot Packs/Ice			
TENS/E-Stim/Laser/Traction			
Yoga/Tai-Chi			
Braces Splints			
Chiropratic Care			
Acupuncture			
Surgery			

Imaging you've had done in regards to this problem:

☐ XRAY Date:_____ Where: _____ ☐ CT Scan Date:_____ Where: _____

☐ MRI Date:_____ Where: _____ ☐ Other Date:_____ Where: _____

Patient/Guardian Signature _____ Date: _____

Name:
DOB:
Acct #:
Age:
Date:

Orthopaedics
OF STEAMBOAT SPRINGS

Orthopaedics of Steamboat Springs 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 OSS personnel to provide medical treatment.
- I understand that I am responsible for any portion of fees or services not covered by my insurance company (non-contracted insurance plans) or services that are not a covered benefit (contracted insurance).
- I also understand that I am responsible in full for all fees if I have provided inaccurate insurance 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 OSS.
- I understand that as a courtesy my insurance 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 OSS and I understand there may be a charge for obtaining these records.
- I aurthorize the facility, Orthopaedics of Steamboat Springs, 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.

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