ALPINE ORTHOPAEDICS & SPORTS MEDICINE, P.C.

112 WEST SPENCER AVENUE
GUNNISON, CO 81230
970.641.6788 / F 970.641.0282

405 ELK AVE
CRESTED BUTTE, CO 81224
970.349.1046 / F 970.349.1049

PATIENT'S FULL NAME | DATE OF BIRTH | AGE | SOCIAL SECURITY #

PERMANENT MAILING ADDRESS/ STREET ADDRESS | CITY/ STATE | ZIP CODE | LOCAL/ CELL PHONE #

BEST WAY TO CONTACT YOU (CIRCLE ONE) PHONE EMAIL

EMAIL ADDRESS

CAN WE LEAVE A PHONE MESSAGE? (CIRCLE ONE) YES NO

PREFERRED LANGUAGE (CIRCLE ONE) ENGLISH SPANISH FRENCH GERMAN
ITALIAN MANDRIN PORTUGESE VIETNAMESE

INSURANCE GUARANTOR (NAME ON INSURANCE CARD IF NOT YOUR OWN) DATE OF BIRTH OF GUARANTOR

COMPLETE SECTION BELOW IF PATIENT IS A MINOR

RESPONSIBLE PARTY (NAME, ADDRESS & PHONE #) DATE OF BIRTH SOCIAL SECURITY #

RESPONSIBLE PARTY'S EMPLOYER (NAME, ADDRESS & PHONE #)

DISCLOSURE AUTHORIZATION

Names of family and/or friends we MAY discuss your treatment/ health information with:

_____ Relationship: _____ Phone number: _____

_____ Relationship: _____ Phone number: _____

_____ Relationship: _____ Phone number: _____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE, i.e. newspaper, radio, internet,etc

REFERRING PHYSICIAN: **PREFERRED PHARMACY:**

RACE (CIRCLE ONE) ASIAN, PACIFIC ISLANDER, NATIVE HAWAIIAN, CAUCASIAN, FILIPINO, MULTIRACIAL, BLACK OR AFRICAN AMERICAN, AMERICAN INDIAN OR ALASKA NATIVE, UNDETERMINDED, CHINESE, JAPANESE, OTHER, DECLINE

ETHNICITY (CIRLCE ONE) NON HISPANIC OR LATINO, HISPANIC OR LATINO, OTHER / UNDETERMINED, DECLINE

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE and FINANCIAL AGREEMENT

I, the undersigned, authorize payment of medical benefits to Alpine Orthopaedics and Sports Medicine, P.C. for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administrating claims of benefits. I certify that I have read and understand and agree that I am financially responsible for all charges whether or not paid by insurance. I am also aware that Alpine Orthopaedics charges $20.00 for all checks returned to them as non-sufficient funds and agree to pay this charge. I agree that I am also financially responsible for all collection fees up to 30% of my charges required to secure this obligation.

DISCLOSURE AUTHORIZATION AND PRIVACY PRACTICES

I allow you to contact those listed above regarding my medical treatment and leave a message on the phone numbers listed above. I acknowledge and agree that I have access to upon request a copy of ALPINE ORTHOPAEDIC & SPORTS MEDICINE, P.C's Notice of Privacy Practices.

SIGNED: _____ DATE: _____

MEDICARE LIFETIME SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ALPINE ORTHOPAEDICS & SPORTS MEDICINE, P.C., FOR ANY SERVICES FURNISHED ME BY THE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED: _____ DATE: _____

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New Patient Medical Information

****This is important information your provider needs to know. Please provide as much information as possible.****

Patient Name: _____ Date of Birth:_____

Age: _____ Weight: _____ Height: _____ Gender:(ciricle one) Male Female Undeterminded

Are you currently under the care of a physician? Y N
If yes, please explain: _____

Primary Care Physician's name, address and phone:_____

Do you use or have you ever used Tobacco? (circle one) Current every day smoker Never Smoked
Current some day smoker Former Smoker
What type of Tobacco? (circle one) Cigarettes Cigars Smokeless Tobacco

Do you use alcohol? Y N
If yes, how often : _____

Have you had any previous fracture or sprains? Y N
If yes, what body part and what year:
_____

Have you had any surgeries? Y N
If yes, what kind and what year:_____

Have you ever had a reaction to anesthesia? Y N
If yes, please explain: _____

Are you taking any daily medications? Y N If yes, please list the medication, dose and instructions:
*Or provide a medication list for us to copy

_____

_____

Are you allergic to any medication(s)? Y N
If yes, list medication and your reaction: _____**(circle one)** Critical Severe Moderate Mild

Do you have any allergies (including foods, latex, iodine, etc)? Y N
If yes, please list each one: _____**(circle one)** Critical Severe Moderate Mild

Do you have a history of:

Y N Abnormal bleeding
Y N Alcohol/ Drug Abuse
Y N Anemia
Y N Arthritis/ Stiff or Painful Joints
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy / Radiation
Y N Clotting Disorder
Y N Colitis
Y N Congenital Heart Disease
Y N Diabetes
Y N Difficulty Breathing
Y N DVT
Y N Emphysema
Y N Epilepsy
Y N Heart Attack/ Heart Murmur/ Heart Surgery
Y N Venereal Disease
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Hemophilia / Blood Disorder
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for any reason
Y N Kidney problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Fevers/ Weight Loss
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Latex Allergy

Family History: Has any family member had any of the following disorders? If so, which relative?

Arthritis: Y N Type, if known: _____ Relative: _____
Heart Disease: Y N Relative: _____
Muscle Disease: Y N Relative: _____
Diabetes: Y N Relative: _____
High Blood Pressure: Y N Relative: _____
Cancer: Y N Relative: _____
Are your parents living? Mother: Y N Age and cause of death: _____
Father: Y N Age and cause of death: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my medical status. I hereby authorize the Doctor/ Physician Assistant to provide medically necessary services, including x-rays, fracture treatment, casting, or procedures in the office, which are determined to be in the best interest of the patient.

Signature of Patient / Legal Guardian: _____ Relationship: _____ Date: _____