

Office Use Only PT Acct # _____

Name: _____ Today's Date: _____
First Middle Initial Last

Mailing Address: _____
City: _____ State: _____ Zip: _____
Physical Address: _____
City: _____ State: _____ Zip: _____

Telephone: () _____ Birth Date: _____ Age: _____
Social Security Number: _____ Gender: M or F
Marital Status: S M D W E-Mail Address: _____

Employer _____ Occupation _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone () _____ Ext. _____

Referring and/or PCP _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone () _____ Birth Date: _____ Age: _____
Social Security Number _____
Employer _____ Occupation _____
Employer's Address: _____
City _____ State _____ Zip _____
Work Phone () _____ Ext. _____

In Case of Emergency Contact: _____ Relationship _____
Home phone () _____ Work phone () _____

Name of Primary Insurance _____
Name of Secondary Insurance _____

Is this a Work Comp or Motor Vehicle Accident? Yes No
If YES, on what Date did the injury occur? _____
Did you report injury to your Employer or Motor Vehicle Insurance? Yes No
Work Comp/MVA Claim Number _____
Adjuster Name: _____
Phone () _____ Fax () _____

WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE.

Health History Form

Name _____ Date of Birth _____ Today's Date _____

Past Medical History:

List all current **medical problems**: _____

List all current **medications**: _____

List all **drug allergies** including adverse reactions.

Review of Systems:

Are you currently having or have you had problems with your:

	Circle		Describe all yes responses
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion/Ulcers	No	Yes	_____
Bowel movement	No	Yes	_____
Bladder problems	No	Yes	_____
Diabetes	No	Yes	_____
Heart problems/Chest Pain (including rheumatic fever)	No	Yes	_____
High blood pressure	No	Yes	_____
High cholesterol	No	Yes	_____
Bleeding problems/Blood clots	No	Yes	_____
Balance problems	No	Yes	_____
Numbness/tingling	No	Yes	_____
Blackout/fainting	No	Yes	_____
Psychological problems/Depression	No	Yes	_____
AIDS/Hepatitis	No	Yes	_____
Cancer	No	Yes	_____
Arthritis/rheumatoid	No	Yes	_____
Polio	No	Yes	_____
Other	Explain _____		

Past Surgical History

Have you ever had any problems with anesthesia? **No** **Yes** Explain _____

Surgery	Year	Complications

Family History

Do any of your grandparents, parents, siblings, or children have the following diseases? Please explain.

Diabetes	No	Yes	_____
High blood pressure	No	Yes	_____
Heart attack	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Rheumatoid arthritis	No	Yes	_____

Social History

Single Married Divorced Separated Widowed
 Do you live alone? No Yes
 Work in the home Employed (occupation _____) Student Retired
 Children? No Yes # _____
 Exercise? Never Rarely Weekly Daily
 What type of exercise? _____
 Smoking? No Yes _____ Packs per day for _____ years.
 Quit smoking? No Yes When? _____
 Previously smoked _____ packs per day for _____ years.
 Chew tobacco? No Yes How much? _____
 Drink alcohol? No Yes How much and how often? _____
 History of substance abuse? No Yes What? _____

Patient Signature _____ **Date** _____
Reviewed by _____ **Date** _____
MD Signature _____ **Date** _____

Tell us about any previous treatments and tests

Who treated you first for this problem? _____

Dr. _____ City: _____

What treatments did you have then? _____

What tests have you had?

CT scan MRI X-ray EMG

Other _____

Did you have any injections for your problem?

no yes, describe _____

Did these injections help?

no yes, describe _____

Did you have previous back or neck surgery?

no yes, describe _____

List any **previous surgeries** you've had, and dates: _____

Did you have physical therapy before for your problem?

no yes, describe _____

Did this therapy help?

no yes, describe _____

Do you do any special exercises for your back or neck? _____

What do you hope we can accomplish today? _____

List any medications you are taking: _____

What other medications have you tried? _____

What other concerns do you have? _____

Reviewed by: _____, MD Date: _____

Tell us about other aspects of your health

List any **allergies** you have to medications, foods, etc.: _____

Do you smoke?

no yes ...how many packs a day? _____

Do you drink alcohol?

no yes ...how many days a week? _____

Do you have any of the following medical problems?

- AIDS/HIV yes no
- Arthritis or joint pain yes no
- Bleeding disorders yes no
- Cancer yes no
- Diabetes yes no
- Epilepsy yes no
- Heart problems yes no
- Hepatitis yes no
- High blood pressure yes no
- Migraines or headaches yes no
- Muscle diseases yes no
- Nerve problems yes no
- Psychiatric problems yes no
- Stomach problems yes no
- Thyroid problems yes no

Recently, have you experienced:

- Fever or chills yes no
- Weight loss yes no
- Chest pain yes no
- Shortness of breath yes no
- Worse pain at night yes no

Tell us about your family history

Do any family members have a history of:

- Back or neck problems yes no
- AIDS/HIV yes no
- Arthritis or joint pain yes no
- Bleeding disorders yes no
- Cancer yes no
- Diabetes yes no
- Epilepsy yes no
- Heart problems yes no
- Hepatitis yes no
- High blood pressure yes no
- Migraines or headaches yes no
- Muscle diseases yes no
- Nerve problems yes no
- Psychiatric problems yes no
- Stomach problems yes no
- Thyroid problems yes no

Other problems? _____

Durango Orthopedic Associates, P.C. Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Durango Orthopedic Associates, P.C.
2. **Authorization for Release or Information:** Durango Orthopedic Associates, P.C. and my physician may release information from my medical records to any health care provider involved in my care and treatment, including Mercy Medical Center. Durango Orthopedic Associates, P.C. and my physician may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Durango Orthopedic Associates, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Durango Orthopedic Associates, P.C. and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Durango Orthopedic Associates, P.C., I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Durango Orthopedic Associates, P.C.
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Durango Orthopedic Associates, P.C. charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Durango Orthopedic Associates, P.C. and my physician for charges not paid.

I acknowledge that:

- I have read this form and understand its contents
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms
- **I am responsible for the payment and/or co-payment that is due at the time of service**

Signature of Patient or Legally Responsible Person

Name (PRINT)

Relationship/Reason Why Patient is Unable to Sign

Date