

Alpine Orthopaedic Specialists

PO Box 6250
North Logan, UT 84341-6250
(435) 787-4400

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN			
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)			
ADDRESS		ADDRESS			
CITY, STATE ZIP		CITY, STATE ZIP			
WORK PHONE		WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$		
CITY, STATE ZIP		DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$		
CITY, STATE ZIP		DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

SIGNATURE OF PATIENT/GUARDIAN

DATE

Name: _____
Chart: _____
Date: _____



ALPINE ORTHOPAEDIC SPECIALISTS

HISTORY FORM

Name: _____ Phone: _____ Birth Date: _____ Date: _____
BP: _____ Pulse: _____ Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____
What problem are you being seen for today? _____
Date/Place/When/How Occurred: _____
Primary Care Physician: _____ Referred By: _____
Prior Treatment: Yes No Prior x-rays? Yes No

DRUG ALLERGIES

WORK HISTORY

CURRENT MEDICATIONS	
Medication	Dosage

Occupation: _____
Does your work involve heavy lifting? Yes No
Standing for long periods of time? Yes No
Sitting for long periods of time? Yes No
What do you do for exercise? _____

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? Yes No Planning Pregnancy? Yes No Are you nursing? Yes No

PAST MEDICAL HISTORY

Please check if you have a past medical history of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Anesthetic problems _____ | <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Prostate disease _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Digestive disorder/Ulcer _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Blood clots _____ | <input type="checkbox"/> Heart problems _____ | <input type="checkbox"/> Smoke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Alcohol: Type/amount _____ |
| <input type="checkbox"/> Chronic rashes _____ | <input type="checkbox"/> Hypertension (High Blood Pressure) _____ | |

FAMILY MEDICAL HISTORY: Please mark any of the conditions that your mother (M), father (F), brother (B), or sister (S) has or had

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding problems _____ | <input type="checkbox"/> Cancer _____ | |

REVIEW OF SYMPTOMS

Please check if you are currently experiencing any of the following symptoms:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bladder incontinence | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Nausea | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other |

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____

Name:

Chart:

Date:



**ALPINE ORTHOPAEDIC SPECIALISTS
FINANCIAL POLICY**

Thank You for choosing Alpine Orthopaedic Specialists as your Health Care Provider. We are committed to giving you excellent medical treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment. All patients must complete our "patient information forms" before seeing the doctor.

CONSENT TO TREAT: I consent to treatment at Alpine Orthopaedic Specialists for services or supplies that have been or may be ordered by the physician. I understand that treatment may include but is not limited to; radiological examinations, injections, laboratory procedures, physical therapy, nursing care, or medical and surgical treatment. I acknowledge that the clinic has not made nor can it make a guarantee of the outcome of treatment.

SELF PAY: Payments on all accounts without insurance are due at the time the service is rendered. A discount is given with payment in full. Monthly budget plans are available if arrangements have been made with the business office and Self Pay Financial Policy has been completed.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will submit claims to your insurance carrier if you have provided us with all the pertinent information to process a claim. We will extend credit for 60 days on approved insurance company benefits if such benefits are assigned to the clinic and if the clinic has sufficient information to verify coverage and submit a proper claim. After 60 days if your insurance has not paid your account in full, we require that you pay the balance. You are also responsible for all deductibles, co-payments, and charges not covered by insurance. I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

LIABILITIES: Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility. We will extend credit for 60 days on liability accounts only if we have the necessary information to exercise our third party rights. If you cannot provide this information, your account is due at the time of service. If your claim has been denied or benefits exhausted the balance is your responsibility and payment in full is required at that time. If your claim is settled and made payable to us any overpayment by you will then be refunded.

UNPAID ACCOUNTS & INTEREST CHARGES: In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all collection agency fees, court costs, and reasonable attorneys fees incurred. We reserve the right to charge interest at the rate of 1 ½ % per month, 18% annually.

CREDIT OPTIONS AVAILABLE: We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and DEBIT CARDS.

I acknowledge that I have reviewed the notice of Privacy Practices which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request. (Initials) _____

*****I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY*****

PATIENT NAME (please print)

DATE

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PRINTED NAME

In case of emergency please contact

Name

Phone

Relationship

Name

Phone

Relationship

Name

Phone

Relationship