CONSENT TO TREAT

I consent to and authorize Bear Lake Orthopaedic Clinic to furnish me, and /or my dependents, with necessary medical care. This medical care may include radiology examination, laboratory testing and other diagnostic procedures as may be required.

RELEASE OF MEDICAL INFORMATION

I consent to and authorize Bear Lake Orthopaedic Clinic to disclose all or part of my, or my dependents medical records to my mutually agreed upon referring physicians.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I consent to and authorize Bear Lake Orthopaedic Clinic to furnish medical information to any third party who may be responsible for payment of all or part of any charges incurred in this office.

I authorize my insurance company, or any responsible third party to pay benefits directly to the Bear Lake Orthopaedic Clinic.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the payment of medical charges incurred on me or my dependents behalf at the office of Bear Lake Orthopaedic Clinic, regardless of third party coverage.

_____ _____

Patient signature/Guardian **Date**

** MEDICARE AUTHORIZATION (IF APPLICABLE) **

I request that payment of authorized Medicare benefits be made on my behalf to Bear Lake Orthopaedic Clinic. I authorize the holder of my medical information to release to the Health Care Financing Administration and its agents any information required to determine those benefits.

_____ _____

Patient signature **Date**

BEAR LAKE ORTHOPAEDIC

Patient's Name:_____ Today's Date:_____

DOB:_____ Weight:_____ Height:_____ AGE:_____

Primary Care Physician:_____ Referring Physician:_____

AFFECTED AREA:

- ☐ KNEE LEFT / RIGHT / BOTH (please circle one)
- ☐ SHOULDER LEFT / RIGHT / BOTH
- ☐ ELBOW LEFT / RIGHT / BOTH
- ☐ WRIST/HAND LEFT / RIGHT / BOTH
- ☐ OTHER:_____

Date of Accident/Injury:_____ Was this an accident? ☐ YES ☐ NO Work Related: ☐ YES ☐ NO

How did the accident/injury occur?_____

X-RAYS taken? ☐ YES ☐ NO **MRI**? ☐ YES ☐ NO **CT SCAN**? ☐ YES ☐ NO

ALLERGIES TO MEDICATIONS:_____

_____

- ☐ I have no known allergies.

MEDICATIONS: Please list below (Include birth control, herbals, dietary supplements and over the counter medications.)

MEDICATION	DOSE/FREQUENCY	MEDICATION	DOSE/FREQUENCY

- ☐ I am not taking any at this time.

SURGICAL HISTORY:

SURGERY/PROCEDUE	YEAR

- ☐ I have not had surgery or a procedure done.

LIFESTYLE:

- Do you chew tobacco? ☐ YES ☐ NO
- Do you consume alcohol? ☐ YES ☐ NO ☐ FORMER DRINKER
- Do you smoke? ☐ YES ☐ NO ☐ FORMER SMOKER
- Do you use recreational drugs? ☐ YES ☐ NO ☐ FORMER DRUG USER

FAMILY HISTORY: (Please check the boxes below if you have a family history of the following)

HEART DISEASE?	**HIGH BLOOD PRESSURE?**	**CANCER?**
☐ None	☐ None	☐ None
☐ Father	☐ Father	☐ Father
☐ Mother	☐ Mother	☐ Mother
☐ Mother's Father	☐ Mother's Father	☐ Mother's Father
☐ Mother's Mother	☐ Mother's Mother	☐ Mother's Mother
☐ Father's Father	☐ Father's Father	☐ Father's Father
☐ Father's Mother	☐ Father's Mother	☐ Father's Mother
☐ Brother	☐ Brother	☐ Brother
☐ Sister	☐ Sister	☐ Sister
☐ Child	☐ Child	☐ Child
ARTHRITIS?	**DIABETES?**	**OSTEOPOROSIS?**
☐ None	☐ None	☐ None
☐ Father	☐ Father	☐ Father
☐ Mother	☐ Mother	☐ Mother
☐ Mother's Father	☐ Mother's Father	☐ Mother's Father
☐ Mother's Mother	☐ Mother's Mother	☐ Mother's Mother
☐ Father's Father	☐ Father's Father	☐ Father's Father
☐ Father's Mother	☐ Father's Mother	☐ Father's Mother
☐ Brother	☐ Brother	☐ Brother
☐ Sister	☐ Sister	☐ Sister
☐ Child	☐ Child	☐ Child

MEDICAL HISTORY: (Please check the boxes below if you have a medical history of the following)

CANCER?	**CARDIOVASCULAR?**	**ENDOCRINE OR METABOLIC?**	**GASTROINTESTINAL?**	**HEAD?**
☐ None	☐ None	☐ None	☐ None	☐ None
☐ Breast	☐ Heart Attacks	☐ High cholesterol	☐ Esophageal spasm	☐ Head Injuries
☐ Lung	☐ Angioplasty with or without stent	☐ High triglycerides	☐ Esophagitis	☐ Frequent headaches
☐ Colon	☐ Coronary bypass surgery	☐ Low HDL	☐ Acid Reflux	☐ Migraines
☐ Prostate	☐ Congestive heart failure	☐ Diabetes	☐ Hiatal Hernia	☐ Other
☐ Cervix	☐ Arrhythmias	☐ Low Thyroid (hypothyroidism)	☐ Ulcer	
☐ Uterus	☐ Stroke	☐ High Thyroid	☐ Gastritis	
☐ Blood	☐ Carotid plaque or endarterectomy	☐ Grave's Disease	☐ Liver cirrhosis	
☐ Melanoma	☐ Claudication or aortic aneurysm	☐ Gout	☐ Hepatitis	
☐ Skin (type)	☐ Venous Thrombosis	☐ Severely overweight	☐ Pancreatitis	
☐ Other	☐ Varicose veins	☐ Cushing's disease	☐ Irritable bowel diverticulosis	
	☐ High Blood Pressure	☐ Pituitary Problems	☐ Diverticulitis colitis	
		☐ Other	☐ Other	

MENTAL OR EMOTIONAL?	**MUSCLE, BONE, OR JOINT?**	**NERVOUS SYSTEM?**	**RESPIRATORY?**	**BLOOD OR LYMPH?**
☐ None	☐ None	☐ None	☐ None	☐ None
☐ Depression	☐ Low back pain	☐ Seizures	☐ Asthma	☐ Anemia (low blood count)
☐ Anxiety	☐ Osteoarthritis	☐ Multiple sclerosis	☐ Chronic Obstructive Pulmonary Disease	☐ Clotting disorder
☐ Panic Attacks	☐ Rheumatoid Arthritis	☐ Peripheral neuropathy	☐ Emphysema	☐ Lymphoma
☐ Manic Episodes	☐ Osteoporosis	☐ Other	☐ Pulmonary embolism	☐ Auto immune disease
☐ Schizophrenia	☐ Systemic lupus erythematosus		☐ Sleep apnea	☐ Other
☐ Other	☐ Other		☐ Other	

☐ I am allergic to Latex.

PLEASE SHOW INSURANCE CARD TO RECEPTIONIST

Payment or co-pay is due at time services are rendered

PATIENT	
Last Name:	Language: English Spanish Other
First Name:	Race: White - Black - African American
Middle Name:	American Indian- Hispanic – Other – Declined to answer
Social Security #:	Ethnicity: Are you Hispanic or Latino? Yes No
Birth Date:	Advanced Directive: Yes No
Birth Place:	Marital Status: Single – Married – Divorced – Separated
Gender: Male Female	Life Partner - Widowed
Mailing Address:	Emergency Contact Name: Phone #:
	Relationship:
City: State: Zip:	INSURANCE
Home Phone:	Primary Insurance:
Cell Phone:	Name on Card:
Email:	Cardholders Birth Date: SS#:
Employer:	ID #:
Employer Address: City: State: Zip:	Group #:
Employer Phone:	Name on Card:
Occupation:	Cardholders Birth Date: SS#:
Spouse Name:	ID#:
Address: o Same as patient	Group #:
Social Security #:	Guarantor:
Birth Date:	
Birth Place:	Last Name:
Cell Phone #:	First Name:
Email:	Social Security #:
Employer:	Birth Date:
Employer Address: City: State: Phone #:	Mailing Address: City: State: Zip:
Occupation:	Occupation:
	Employer:
Pharmacy:	Employers address:
	Employers phone: