



Patient Intake Form - DR Kelleher

Patient Name: _____

What is your occupation? _____

Are you right or left handed (circle one)

What are we seeing you for today? _____

Is the reason for your visit today injury related? Yes No

Is this work related? Yes No

Date of injury or onset of symptoms: _____

Please briefly describe your problem/the injury: _____

Have you been evaluated by another provider, physical therapist, chiropractor, acupuncturist, etc.? Yes No

If yes, where and how long? _____

Have you had any injections or prior surgeries for this problem? Yes No

Are you taking any medications for the pain? (Prescription, Ibuprofen, Aleve, Tylenol, etc)

Please List: _____

Please describe the pain. (Example: sharp, dull, throbbing, aching, etc.) _____

On a scale of 0-10 with 10 being the worst imaginable pain, please rate your current pain: _____

Is this problem causing difficulty with your sleep? Yes No

Please check the symptoms that apply. Then list the area of your body where you are experiencing the symptom.

Swelling: _____ Popping or clicking: _____ Instability: _____

Locking: _____ Stiffness: _____ Pain at night: _____

Numbness/tingling: _____ Weakness: _____ Other: _____

Does anything improve your symptoms? _____

Does anything make your symptoms worse? _____

Are there any activities that your symptoms prevent you from doing? _____

PATIENT INFORMATION

Print Name: _____ Sex: Male Female
Mailing Address: _____ Date of Birth: _____
City, State, Zip: _____ Social Security # (REQUIRED): _____
Physical Address: _____ Marital Status: Married Single Divorced
City, State, Zip: _____ Email Address: _____
Home Phone: _____ Work: _____ Who Referred You: _____
Cell/ Pager Phone: _____ Primary Physician: _____
Preferred method for appointment reminders Phone Email Text

PATIENT EMPLOYMENT INFORMATION

Employed Retired Unemployed Other
Employer's Name: _____
Employer's Phone: _____
Occupation: _____

EMERGENCY CONTACT

Name: _____
Relationship: _____
Phone: _____

RESPONSIBLE PARTY (If Patient is Under 18 Years of Age)

Name: _____ Employer: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Social Security # (REQUIRED): _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

PRIMARY INSURANCE

Insurance Company Name: _____
ID #: _____ Group/Policy #: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's Social Security # (REQUIRED): _____ Subscriber's Date of Birth: _____
Subscriber's Phone #: _____ Subscriber's Employer: _____

WORKER'S COMPENSATION OR ACCIDENT RELATED INJURY

Compensation Provider Name: _____ Adjuster's Name: _____
Address: _____ Phone #: _____
City, State, Zip: _____ Fax #: _____
Claim #: _____ Date of Injury: _____
Employer at Time of Injury: _____

PATIENT DEMOGRAPHIC INFORMATION

Prefer not to share this information

Race: American Indian or Alaska Native Asian Black or African American Hawaiian or Pacific Islander
 White Other Race Unknown
Ethnicity: Hispanic or Latino Non-Hispanic or Non-Latino Unknown
Principle Language: English Arabic Chinese French German Italian Japanese Spanish Vietnamese

YOUR MEDICAL RECORDS WILL BE RETAINED FOR NO LONGER THAN 7 YEARS

ALPINE ORTHOPEDICS & SPORTS MEDICINE COMPLIES WITH APPLICABLE FEDERAL CIVIL RIGHTS LAWS AND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY OR SEX.

SIGNATURE of Responsible Party _____ Relationship _____ Date _____



Patient Medical Profile

ALPINE
ORTHOPEDECS
& SPORTS MEDICINE

Patient Name : _____ Age: _____
Who may we thank for referring you to us? _____
Primary care physician (if different): _____
Reason for visit: _____
Date of injury / Onset of problem: _____

CURRENT HEALTH

Please list any medical problems you have or have been diagnosed with: **NO PROBLEMS** Height: _____
Weight: _____
 Heart disease or attack Stroke Osteoporosis / Low Bone Density
 Diabetes Cancer Stomach ulcers **Please list other medical problems:**
 High blood pressure Thyroid problems Heartburn / Reflux _____
 High cholesterol Kidney disease Rheumatoid arthritis _____
 Asthma DVT (Blood clot) Gout / Psedogout _____
 COPD / Emphysema Chronic headaches Depression _____

Females Only: Date of last menstrual period: _____ Currently Pregnant? Yes No Possibly

SURGICAL HISTORY

Please list all previous surgeries and the approximate year: **I HAVE NOT HAD ANY SURGERIES**

Surgery:	Year:	Surgery:	Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have allergies or any problems with anesthesia? No Yes Describe: _____

MEDICATIONS

Please list any medication you currently use, including over-the-counter medications, vitamins, and supplements: _____

_____ **I TAKE NO MEDICATION**

ALLERGIES

NO KNOWN DRUG ALLERGIES Penicillin Iodine Latex
 Sulfa Drugs Diagnostic Dyes Adhesive Tape
 Other: _____

FAMILY HISTORY

Does anyone in your immediate family (parents, brothers, sisters, children) have any of the following? **NONE**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Hip Problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lupus	<input type="checkbox"/> Back Disc Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Psoriasis	

SOCIAL HISTORY

Current / Past Occupation: _____ I am Disabled Reason: _____

Who lives with you? _____ I live alone

Do you drink alcohol? No Yes How Often? Daily Weekly Monthly Infrequently

Do you smoke? No I quit in _____ (year) Yes Number of packs daily: _____

Do you use any other substances? Smokeless tobacco Recreational drugs Please list: _____

REVIEW OF SYSTEMS

Please circle any that apply to you:

General	Fevers	Chills	Night sweats	Fatigue	Loss of appetite	Weight loss	Weight gain
Eyes	Blurred vision	Eye pain	Glasses / Contacts				
Ear, Nose, Throat	Hearing loss	Mouth sores	Voice changes	Frequent nose bleeds			
Cardiovascular	Heart attack	Chest pain	Palpitations	Leg swelling	Heart murmur		
Respiratory	Sleep apnea	Wheezing	Chronic cough	Tuberculosis			
Gastrointestinal	Frequent diarrhea	Heartburn	Constipation	Nausea / Vomiting	Blood in stool		
Genitourinary	Kidney stones	Incontinence	Frequent urination	Painful urination	Blood in urine		
Musculoskeletal	Joint swelling	Back pain	Trouble walking	Weakness			
Skin	Color change	Rash	Cellulitis	Psoriasis			
Neurologic	Headaches	Dizziness	Bad balance	Numbness / Tingling			
Hematologic	Enlarged glands	Anemia	Bleeding disorders				
Psychological	Depression	Anxiety	Trouble sleeping	Memory loss			
Other (please list):	_____						

MISCELLANEOUS INFORMATION

Please list any more information that may be important to your visit today.

SIGNATURE

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of patient (parent or guardian if the patient is a minor)

Date

Reviewed and updated by **PHYSICIAN**:

Initials

Initials

Initials

Initials

Initials

Initials

Initials

Date

Date

Date

Date

Date

Date

Date

Reviewed and updated by **PATIENT**:

Initials

Initials

Initials

Initials

Initials

Initials

Initials

Date

Date

Date

Date

Date

Date

Date

Privacy Practice Record

I have received the Alpine Orthopedics and Sports Medicine notice of Privacy and Practice Standards of Protected Health Information.

I authorize Alpine Orthopedics and Sports Medicine to request and review my records from any entity in which my provider is affiliated.

Signature: _____ Date: _____

I authorize my provider and those acting on their behalf to release any medical information regarding my treatment in this practice in accordance with the HIPAA notice I have been provided, and further, to:

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Alpine Orthopedics
536 Cottonwood, Ste 100
Bozeman, MT 59718
406-586-8029

Financial Policy

It is your responsibility to verify coverage. We will make every attempt to pre-authorization of any services, supplies or procedures but pre-authorization does not ensure payment by your insurance company. Please contact your insurance company prior to any services being rendered if you have questions about what services may or may not be covered.

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account regardless of insurance coverage or other third party involvement. I hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services

I am aware that my insurance carrier may consider some services and/or supplies "non-covered", therefore I will become fully responsible for the payment of these charges.

Assistant Surgeon Charges

I am aware that should I have a surgical procedure, my doctor may require the assistance of a qualified assistant surgeon, P.A or surgical RN. The assistant fee is 20% of the surgeon's fee per procedure. I am aware that I am responsible for these charges if not covered by my insurance.

Insurance Assignment and Release of Information

I hereby assign benefits to be paid directly to Alpine Orthopedics and Sports Medicine. I hereby authorize Alpine Orthopedics and Sports Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that my account becomes past due, I understand that I agree to pay all collection costs, attorney costs and court costs necessary to collect payment. I have read all of the above and understand/agree to all the provisions therein regarding my financial responsibility and release of information.

PRINT Patient's Name: _____ Date: _____

Patient or Legal Guardian's Signature: _____

If Legal Guardian, Relationship to Patient: _____