ALPINE
ORTHOPEDICS & SPORTS MEDICINE

Patient Intake Form – DR Stark

Patient Name:_____ Age:_____ Date:_____

What are we seeing you for today?_____

Is the reason for your visit today injury related? ☐ Yes ☐ No Date of injury or onset of symptoms: _____

Is this work related? ☐ Yes ☐ No Where did injury occur?_____

Please briefly describe your problem/the injury:_____

_____

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

If yes, by whom and what date(s)?_____

Have you had previous imaging/studies? ☐ Yes ☐ No Please circle type: X-rays MRI CT Nerve Tests

Date and Facility:_____

Have you had any injections or prior surgeries for this problem?

☐ Yes ☐ No If yes, date/description_____

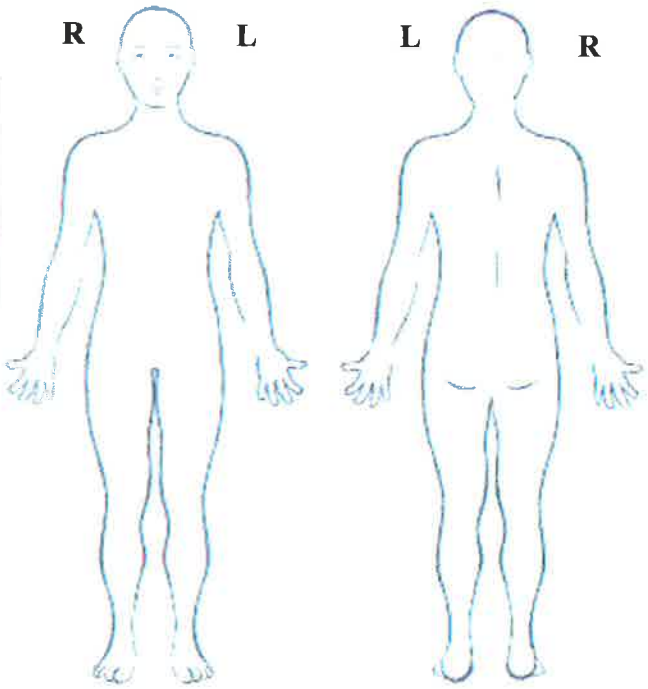
Please indicate your symptoms on the model using the following symbols:

(+) Ache

(O) Numbness

(*) Pins/Needles

(///) Sharp/Stabbing



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

Are you taking any pain medications? ☐ Yes ☐ No

If yes, pleas list:_____

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: _____

Any change in bowel or bladder function? ☐ Yes ☐ No

Does anything improve your symptoms?_____

Does anything make your symptoms worse?_____

How far can you walk without stopping? _____

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

_____

_____

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

PATIENT INFORMATION

Print Name: _____
Mailing Address: _____
City, State, Zip: _____
Physical Address: _____
City, State, Zip: _____
Home Phone: _____ Work: _____
Cell/ Pager Phone: _____
Preferred method for appointment reminders ☐ Phone ☐ Email ☐ Text

Sex: ☐ Male ☐ Female
Date of Birth: _____
Social Security # (REQUIRED): _____
Marital Status: ☐ Married ☐ Single ☐ Divorced
Email Address: _____
Who Referred You: _____
Primary Physician: _____

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: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone:

Employer: _____
Date of Birth: _____
Social Security # (REQUIRED): _____
Cell Phone: _____

PRIMARY INSURANCE

Insurance Company Name: _____
ID #: _____
Subscriber's Name: _____
Subscriber's Social Security # (REQUIRED): _____
Subscriber's Phone #: _____

Group/Policy #: _____
Relationship to Patient: _____
Subscriber's Date of Birth: _____
Subscriber's Employer: _____

WORKER'S COMPENSATION OR ACCIDENT RELATED INJURY

Compensation Provider Name: _____
Address: _____
City, State, Zip: _____
Claim #: _____
Employer at Time of Injury: _____

Adjuster's Name: _____
Phone #: _____
Fax #: _____
Date of Injury: _____

PATIENT DEMOGRAPHIC INFORMATION

☐ **Prefer not to share this information**

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawiian or Pacific Islander ☐ White ☐ Other Race ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown

Principle Language: ☐ English ☐ Arabic ☐ Chinese ☐ French ☐ German ☐ Italaian ☐ 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 ORGIN, AGE, DISABILITY OR SEX.

SIGNATURE of Responsible Party _____ **Relationship** _____ **Date** _____

ALPINE
ORTHOPEDICS & SPORTS MEDICINE

Patient Medical Profile

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
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Stroke
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Kidney disease
- ☐ DVT (Blood clot)
- ☐ Chronic headaches
- ☐ Osteoporosis / Low Bone Density
- ☐ Stomach ulcers
- ☐ Heartburn / Reflux
- ☐ Rheumatoid arthritis
- ☐ Gout / Psedogout
- ☐ Depression

Please list other medical problems:

_____

_____

_____

_____

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
- ☐ Sulfa Drugs
- ☐ Iodine
- ☐ Diagnostic Dyes
- ☐ Latex
- ☐ Adhesive Tape

☐ Other: _____

FAMILY HISTORY

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

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma
- ☐ Blood Clots
- ☐ Gout
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Hip Problems
- ☐ Back Disc Problems
- ☐ Ankylosing Spondylitis
- ☐ Psoriasis
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Other: _____

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
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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 theses 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 theses 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: _____