PINNACLE orthopedics

Name _____ Gender: M F Other

Marital Status_____

Date of birth ____/_____/_____

Mailing address_____

Phone_____

Email address _____

Emergency Contact_____

Emergency phone_____

Relation to emergency contact _____

Permission to release medical information to the emergency contact Y or N

Social security number _____

Primary care provider _____

Preferred Pharmacy_____

Occupation_____ Employer_____

Reason for today's visit: Right/ Left/ Both_____

Date when symptoms started_____

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Please list current medications below

Please list all allergies to food, medications, environmental and list reaction:

Medical history:

- o Diabetes
- o High blood pressure
- o Heart disease
- o Arthritis
- o Cancer
- o Stroke
- o Thyroid

List any other medical illnesses or problems.

_____

_____

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List all past Orthopedic surgeries and date of surgeries.

_____

_____

_____

_____

List any additional surgeries.

_____

_____

_____

_____

Family Medical History:

Mother (mark one) **O Alive** **O Deceased**

Reason:_____

Father (mark one) **O Alive** **O Deceased**

Reason:_____

All other pertinent family medical history list below **(siblings, aunts, uncles, grandparents)**

_____

_____

_____

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Social History:

Tobacco smoking history (circle): Current daily smoker Current occasional smoker Never Smoker

Former smoker year quit _____

Alcohol intake (circle): Socially Occasional Does not drink

Drug use (circle): Never Occasional Frequent Type: _____

Relationship status: Married Single

Recreational activities

_____

Review of Systems: Please indicate ALL that you have experienced within the past 6-12 months (please circle)

- Fever/ Chills
- Headache/ Dizziness /Weakness
- Shortness of breath / Cough
- Chest pain /Palpitations
- Nausea /Vomiting / Diarrhea/ Constipation
- Burning on urination
- Rashes /Itching
- Bruising/ Bloody noses
- Depression/ Anxiety
- Excess Thirst
- Blurry/ Double Vision
- Hearing problems
- Musculoskeletal:_____

By signing below, I acknowledge that I have received and reviewed the "Notice of Privacy Practices".

Patient Signature _____ Date _____

Parent Signature (for minors) _____

Gunnison office
711 North Taylor Street
Gunnison, CO 81230
CB office:
510 Elk Avenue Suite 2
Crested Butte, CO 81224

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent from is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits or any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of personal representative Relationship to patient

_____ _____
Printed name and signature of witness Date and job title

PINNACLE
orthopedics

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Pinnacle Orthopedics and Sports Medicine on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Pinnacle Orthopedics and Sports Medicine to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Pinnacle Orthopedics and Sports Medicine. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party — Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party — Relationship to patient.