

Appointment Doctor \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT INFORMATION (CHILDS name if applicable):**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**RESPONSIBLE PARTY / PARENT PRESENT WITH CHILD**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**SPOUSE / OTHER RESPONSIBLE PARTY**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**INSURANCE 1**

Ins. Co. Name \_\_\_\_\_

Insured Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ SSN \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Pre Certification Phone # \_\_\_\_\_

**INSURANCE 2**

Ins. Co. Name \_\_\_\_\_

Insured Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ SSN \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Pre Certification Phone # \_\_\_\_\_

**CURRENT INJURY INFORMATION**

Type: Accident Work Auto Date \_\_\_\_\_

Place \_\_\_\_\_ Time \_\_\_\_\_

Body Part: \_\_\_\_\_ Right Left Bilateral

Description of Accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RELATIVE / FRIEND NOT LIVING IN HOME**

Last \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**\*Disclosure of this information is voluntary. However, failure to provide this information will result in no credit being extended and all services must be paid for at the time they are rendered.\***

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. Charges shown by statements are agreed to be correct and reasonable, unless protested in writing within thirty days of the billing date. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I authorize Casper Orthopaedic Associates, P.C. to obtain credit/employment information required for collection purposes.

X-rays taken at Casper Orthopaedic Associates, P.C. will remain the property of Casper Orthopaedic Associates, P.C. Copies of x-rays can be provided for a small fee.

It may be necessary for additional tests to be ordered and performed outside of Casper Orthopaedics Associates, P.C. I authorize transfer of medical information, patient information and insurance information to the following outside sources: Wyoming Medical Center, Casper Surgical Center, Wyoming Surgical Center, Wyoming Imaging Center, Casper Medical Imaging, Diagnostic Lab, and Medical Testing Lab and/or other medical facilities if indicated. I have the right to amend, revoke and to obtain a written report annually of all disclosures of health information.

Casper Orthopaedics will routinely call the patient to remind them of an upcoming appointment. A message will be left on your voice mail or answering machine regarding the date and the time of that appointment.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

I have received the Patient Information Brochure \_\_\_\_\_ / \_\_\_\_\_  
Patient Signature Date

### PRIVACY NOTIFICATION

By signing below, you acknowledge that you have been informed of the Notice of Information Privacy Practices ("Notice") from Casper Orthopaedic Associates, P.C. You have the right to review our Notice prior to signing this acknowledgment. The terms of the Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Casper Orthopaedic, P.C. at (307) 265-7205 and request a revised Notice. We will also post any revised Notice at 4140 Centennial Hills Boulevard. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to those restrictions.

Acknowledgment \_\_\_\_\_ Date \_\_\_\_\_

### INSURANCE OPTION

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions they took before they received the revocation.

Insurance 1 \_\_\_\_\_ Insurance 2 \_\_\_\_\_

Insured Policy Holder Name \_\_\_\_\_ Insured Policy Holder Name \_\_\_\_\_  
(Signature) (Signature)  
Date \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

Are you experiencing pain associated with the condition for which you are being seen? \_\_\_\_\_

Please rate your pain from 0-10 Pain Rating Scale \_\_\_\_\_ (0 = no pain, 10 = severe pain)

Do you have a living will or durable Power of Attorney? Copy in chart?  yes  no

Allergies	Reactions	Past Medical History Have you had a history of:
Latex <input type="checkbox"/> No <input type="checkbox"/> Yes		Please check appropriate answer Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes
		Lung Disease <input type="checkbox"/> No <input type="checkbox"/> Yes (Asthma, emphysema, chronic bronchitis)
		High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes
		Vascular Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Current Medications / Herbs	Dose	Heart Attack <input type="checkbox"/> No <input type="checkbox"/> Yes
		Congestive Heart Failure <input type="checkbox"/> No <input type="checkbox"/> Yes
		Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes
		Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes
		Insulin <input type="checkbox"/> No <input type="checkbox"/> Yes
		Rheumatoid Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes
		Lupus <input type="checkbox"/> No <input type="checkbox"/> Yes
		Gout <input type="checkbox"/> No <input type="checkbox"/> Yes
		Chronic Urinary Infection <input type="checkbox"/> No <input type="checkbox"/> Yes
		MRSA
		Do you take pain meds <input type="checkbox"/> No <input type="checkbox"/> Yes
		Pain Contract? <input type="checkbox"/> No <input type="checkbox"/> Yes
Previous Surgeries		Date

Have you or family members ever had problems with anesthesia? (i.e., high fever)  No  Yes

Have you had an EKG in the past 3 months?  No  Yes If so, where? \_\_\_\_\_

CONTINUED TO NEXT PAGE

Has anyone in your immediate family had:

Heart disease  No  Yes \_\_\_\_\_

Diabetes  No  Yes \_\_\_\_\_

Other: \_\_\_\_\_

**Social History**

Employed (Occupation) \_\_\_\_\_ Unemployed Student Homemaker

Marital Status \_\_\_\_\_

If appropriate – Are you pregnant at this time  No  Yes

Is there someone in the home that could assist if needed  No  Yes Name: \_\_\_\_\_

Exercise Daily Weekly Monthly Rarely Never

What type of exercise \_\_\_\_\_

Exercise Tolerance: How many flights of stairs can you climb before becoming short of breath? \_\_\_\_\_

Are you on a special diet  No  Yes Describe \_\_\_\_\_

History of substance abuse  No  Yes What \_\_\_\_\_

Smoke Currently  No  Yes \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Quit smoking  No  Yes When \_\_\_\_\_

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Drink alcohol None Daily 1-2 x/week 1-2 x/month 1-2 x/year \_\_\_\_\_

**Review of Systems**

Are you currently having, or have you had problems with your: Please describe all Yes responses

- Eyes/Vision  No  Yes \_\_\_\_\_
- Ears, Nose, Throat  No  Yes \_\_\_\_\_
- Shortness of breath  No  Yes \_\_\_\_\_
- Digestion/Reflux  No  Yes \_\_\_\_\_
- Bowel Movement  No  Yes \_\_\_\_\_
- Bladder Problem  No  Yes \_\_\_\_\_
- Chest Pain/Heart  No  Yes \_\_\_\_\_
- Bleeding Problems  No  Yes \_\_\_\_\_
- Blood Clots/DVT  No  Yes \_\_\_\_\_
- Balance Problems  No  Yes \_\_\_\_\_
- AIDS/HIV  No  Yes \_\_\_\_\_
- Immune System  No  Yes \_\_\_\_\_
- Arthritis/Joint Stiffness  No  Yes \_\_\_\_\_
- Skin  No  Yes \_\_\_\_\_
- TB/Infection  No  Yes \_\_\_\_\_
- Cancer  No  Yes \_\_\_\_\_
- Hepatitis/Jaundice  No  Yes \_\_\_\_\_
- Cold/Cough/Flu  No  Yes \_\_\_\_\_

Have you ever been diagnosed with sleep apnea?  No  Yes \_\_\_\_\_

Are you currently being treated with C-PAP?  No  Yes \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_, MD Date: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_, MD Date: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_, RN Date: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_, RN Date: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_, RN Date: \_\_\_\_\_

POS: \_\_\_\_\_ Date: \_\_\_\_\_