

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 _____

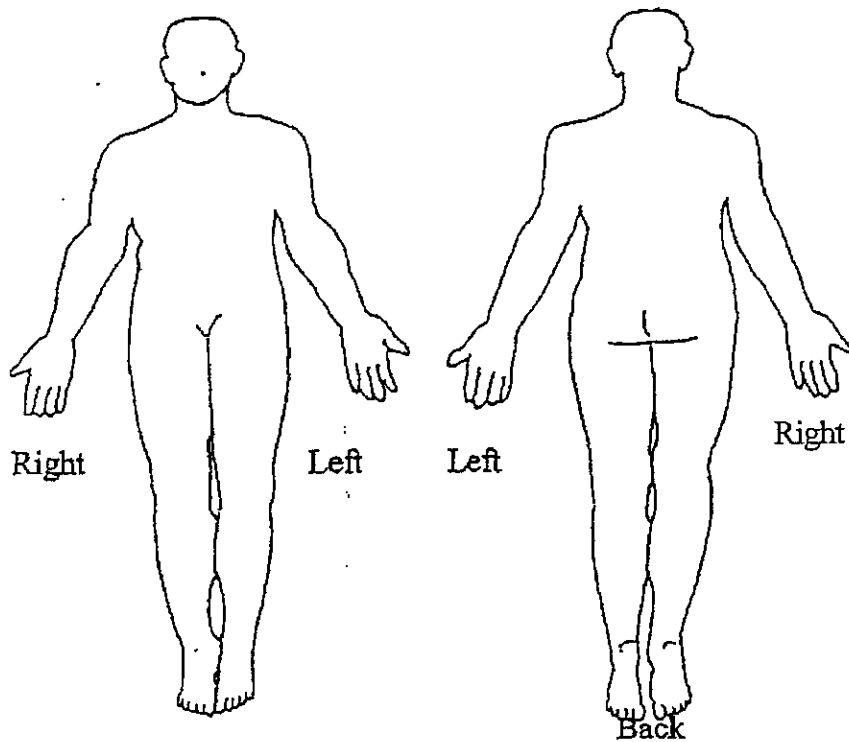
PAIN DIAGRAM - FOLLOW-UP

Name _____ Age _____ Gender M/F Date _____

Height _____ Weight _____ Date of Injury _____

Please mark the areas where you experience the following sensations:

Ache AAA Numbness NNN Pins & Needles PPP Burning BBB Stabbing SSS



What medications are you taking for pain?

Do you need refills Yes / No ?

Since your last office visit are you: Better Worse The same? Please circle your answer.

How bad is your pain? Place an "X" (X) on each of the lines below to indicate your current pain.

How bad is your low back pain?

No pain _____ Worst possible

How bad is your leg pain?

No pain _____ Worst possible

How bad is your middle back pain?

No pain _____ Worst possible

How bad is your neck pain?

No pain _____ Worst possible

How bad is your arm pain?

No pain _____ Worst possible