COLORADO
ADVANCED
ORTHOPEDICS
SPORTS MEDICINE & SPINE
PIONEERS MEDICAL CENTER

100 Pioneers Medical Center Drive
Meeker, Colorado 81641
(970) 878-9752 (p)
(970) 878-9745 (f)
www.coloradoadvancedorthopedics.com

GENERAL INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

MAILING ADDRESS/STREET/PO BOX _____ CITY _____ STATE _____ ZIP _____

HOME/WORK/CELL _____ ALTERNATE PHONE NUMBER _____ EMAIL _____

GENDER _____ DOB _____ SOCIAL SECURITY NUMBER _____

MARITAL STATUS _____ LANGUAGE _____ RACE _____ ETHNICITY _____

PLACE OF EMPLOYMENT _____

GUARANTOR: NAME/ADDRESS/PHONE _____ RELATIONSHIP TO PATIENT _____

IF PATIENT IS A MINOR: GRANTOR'S DOB, EMPLOYMENT, NAME, ADDRESS & PHONE NUMBER _____

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INSURANCE INFORMATION

_____	_____	_____
PRIMARY INSURANCE	ID NUMBER	GROUP NUMBER

_____

POLICY INSURANCE HOLDER (IF DIFFERENT FROM ANY ABOVE) NAME, ADDRESS, DOB & PHONE NUMBER

_____	_____	_____
SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER

_____

POLICY INSURANCE HOLDER (IF DIFFERENT FROM ANY ABOVE) NAME, ADDRESS, DOB & PHONE NUMBER

EMERGENCY CONTACT INFORMATION

_____	_____	_____
NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
NEXT OF KIN NAME	PHONE NUMBER	RELATIONSHIP

_____	_____
SIGNATURE OF PERSON FILLING OUT FORM	DATE

_____

PRINTED NAME OF PERSON FILLING OUT FORM

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PATIENT INTAKE & HISTORY FORM

NAME: _____ DOB: _____

PLACE OF EMPLOYMENT & OCCUPATION: _____

SPOUSE/PARTNER NAME: _____

	NONE	SELF	MOTHER	FATHER
Anti-Coagulation	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Arthritis/Lupus	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Cardiac Stent	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
DVTs	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐

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Tobacco Use: YES ☐ NO ☐ *If yes, for how long?* _____ *How much?* _____

Alcohol: YES ☐ NO ☐ *If yes, how many drinks per week?* _____ *Whisky/Beer/Wine*

Recreational/Illegal Drugs: YES ☐ NO ☐ *If yes, what and for how long?* _____

Allergies: YES ☐ NO ☐

If yes, please list all known allergies, including medication allergies and type of reaction to the allergen:

_____
_____
_____

Orthopedic/General Surgeries/Bone Density – please list all surgeries and their respective year:

_____
_____
_____

Medications, including vitamins and supplements – please include the dosing and number of times per day you take them:

_____
_____
_____
_____
_____
_____

Pharmacy: _____

Mail Order Pharmacy: _____

Primary Care Physician (PCP): _____

PCP's Address: _____

PCP's Phone Number: _____

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AUTHORIZATION FOR INFORMATION

*Please note: This is **NOT** an authorization for release of medical records, which requires and Authorization to Disclose Health Information Form.*

I, _____, authorize, _____ to be able to:

1. Pick up prescriptions for me ☐
2. Speak to a physician or staff member regarding my Personal Health Information (PHI) or billing information ☐
3. Pick up paperwork, such as billing information ☐

Unless otherwise indicated below, this Authorization for Information form expires one calendar year (12-months) from the date of signature. This Authorization for Information form remains valid until its expiration date indicated below, unless effectively revoked in writing, by me, before that date.

I have chosen to terminate this authorization, sooner than one-year, on the following date:

Date: _____

_____ _____

Signature Date