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

_____

EMPLOYMENT STATUS

_____ _____

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

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PATIENT INTAKE & HISTORY FORM

NAME: _____ DOB: _____

PLACE OF EMPLOYMENT & OCCUPATION: _____

SPOUSE/PARTNER NAME: _____

Review of Systems: Do you suffer from the following:

Cardiovascular

Heart Attack	◯Yes ◯ No
Heart Failure	◯Yes ◯ No
Stroke	◯Yes ◯ No
High Blood Pressure	◯Yes ◯ No
Poor Circulation	◯Yes ◯ No

GI / GU

Stomach Ulcers	◯Yes ◯ No
Hiatal Hernia	◯Yes ◯ No
Acid Reflux (GERD)	◯Yes ◯ No
Cirrhosis (Liver Disease)	◯Yes ◯ No
Kidney Disease /Failure	◯Yes ◯ No

Endocrine

Diabetes	◯Yes ◯ No
Controlled with Oral Meds	◯Yes ◯ No
Controlled with Insulin	◯Yes ◯ No
Thyroid	◯Yes ◯ No

Psychiatric/ Mental Health

Depression	◯Yes ◯ No
Anxiety	◯Yes ◯ No
Other:	

_____

Respiratory

Emphysema	◯Yes ◯ No
Asthma	◯Yes ◯ No
Lung Disease (COPD) Pneumonia	◯Yes ◯ No
Sleep Apnea **Musculoskeletal**	◯Yes ◯ No
Fractures	◯Yes ◯ No
Osteoarthritis	
Rheumatoid Arthritis	
Osteoporosis	
Gout	◯Yes ◯ No
	◯Yes ◯ No
	◯Yes ◯ No

Hematology

Blood clot in leg	◯Yes ◯ No
Blood clot in Lung	◯Yes ◯ No
Bleeding Disorder	◯Yes ◯ No
Anemia	◯Yes ◯ No
HIV/AIDS	◯Yes ◯ No

OTHER:

Hearing Loss	◯Yes ◯ No
Vision Loss	◯Yes ◯ No
Neuropathy (loss of Feeling)	◯Yes ◯ No
Seizure	◯Yes ◯ No
Skin: ◯Rash ◯Hives ◯Eczema	◯Yes ◯ No
	◯Yes ◯ No
	◯Yes ◯ No
	◯Yes ◯ No

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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