SALT LAKE ORTHOPAEDIC CLINIC

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Date: _____ Account Number: _____

Please complete and return this form to the receptionist. Please read and sign the reverse side. **Ref: Physician** _____
We will file with your insurance company if you supply us with complete insurance information.

PATIENT INFORMATION

Patient's Name (First, Middle, Last)

Patient's Address

City State Zip

Date of Birth Age Sex Soc. Sec. No.

Home Phone Work Phone Marital Status

Employer

Employer's Address (Street)

City State Zip

Occupation (Indicate if Student) Number of Children

Nearest Relative/Friend (local, not in same household)

Nearest Relative's/Friend's Address

Phone

City State Zip

FILL IN FOR HUSBAND OR WIFE

Spouse's Name

Employer Phone

Employer's Address City State Zip

FILL IN IF PATIENT IS A MINOR

Parent's Name (First, Middle, Last)

Employer

Employer's Phone

Employer's Address

City State Zip

Parent's Name (First, Middle, Last)

Employer

Employer's Phone

Employer's Address

City State Zip

INSURANCE

Primary Insurance Phone

Name of Policyholder

Insurance Address (City, State, Zip)

Date Last Worked Date Returned to Work

Policy Number Group Number

Secondary Insurance Group Number

Name of Policyholder Policy Number

Insurance Address (City, State, Zip)

Reason for Visit Date of Injury

INDUSTRIAL

Employer at Time of Injury Phone

Street Address City State Zip

Claim Number Reported Injury ☐ Yes ☐ No

Date of Injury Date Last Worked Date Returned to Work

State Accident Occurred County Accident Occurred

Industrial Insurance Carrier

Street Address City State Zip

Type of Injury

AUTO RELATED?

Automobile Insurance

Claim Number

Street Address City State Zip

Name of Insured

Date of Accident State of Accident

Date Last Worked Date Returned to Work

Type of Injury

The Salt Lake Orthopaedic Clinic (SLOC) Financial Policy

Patient Name_____

It is our office policy to inform you of our patient payment procedures. SLOC bills insurance as a courtesy. **The contract you have with your insurance is between you and your insurance carrier. That insurance contract is not between your carrier and SLOC.**

Please review the sections below.

1. Patient with Insurance

You are responsible for deductibles, co-pays, non-covered services, co-insurance, and items considered "not a covered benefit" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. Any balance unpaid after sixty (60) days from the date services were rendered will be considered "delinquent." If you or your insurance carrier make payments exceeding your balance reimbursement will be remitted. If payment cannot be made at each visit, notify the account coordinator so that other arrangements can be made. **It is the responsibility of the patient to determine that the physician you see is a participating provider on your insurance plan. If your physician is not a participating provider, if you are ineligible for insurance, or have given erroneous information, you will be responsible for the balance.**

2. Workers' Compensation Patient

As a Workers' Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment.

Patient is ultimately responsible for balance.

3. Personal Injury (Accident)

If you are a personal-injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing. **Patient is ultimately responsible for balance.**

4. Medicare/Medicaid

Our office will submit your Medicare/Medicaid charges to Medicare/Medicaid and your secondary insurance. Patient hereby agrees to be responsible for deductibles, co-pays, and any non-covered services.

5. Return Check Charges

A return check handling charge of $20.00 will be applied to all returned checks.

6. Interest Rate

You are responsible for payment of your bill. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of $0.50 per month.

7. Forms

There will be a $20.00 charge for any type of form (excluding Work Comp. Form 123)

ATTORNEY'S FEES AND COSTS: If any legal action is necessary to enforce the terms of this Agreement, or if it is necessary to employ the services of an attorney, the Patient agrees to pay the Clinic's reasonable attorney's fees and court costs in addition to any other relief to which it may be entitled. If Patient fails to pay any amounts owing hereunder when due, or otherwise breaches any terms of this Agreement, Patient agrees to pay the collection expense incurred by SLOC in attempting to collect such amounts from Patient, in addition to the aforementioned attorney's fees and costs.

RELEASE OF INFORMATION

ASSIGNMENT

_____ I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to the Salt Lake Orthopaedic Clinic for any service furnished me by SLOC.

_____ The Signature below authorizes payment of mandated Medigap benefits to SLOC.

_____ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to receive.

_____ I authorize SLOC to release my protected health information for treatment, payment, or operations as defined by HIPPA laws.

X_____ _____

Patient or responsible party signature — Date

_____ _____

Person signing on behalf of patient (print name) — Relationship to Patient

_____

Witness

Salt Lake Orthopaedic Clinic
Medical History

Name:_____ Today's Date:_____ SS#:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Referring Physician:_____

Chief Complaint

Why are you seeing the doctor today?_____

List any treatment, test, or X-rays you have had for this problem:_____

Current problem is the result of a(n):_____Car accident_____Work Accident_____Other Accident_____NOT Accident Related

Date of Accident	Location (Home, School, Work, etc.)	Details of Accident or Injury

This occurred during: Check all that apply

Lifting	Pulling	Pushing	Twisting	Falling
Reaching	Squatting	Hit by Object	Not Known	Bending

Current Medical Problems:

Medication: Dose Times/Day How Long

Allergies:

Review of Systems

Are you currently having or have you had problems with:

General or Constitutional		**Circle**
High blood pressure	No	Yes
Skin problems	No	Yes
Recent exposure to communicable diseases	No	Yes
Malignant hyperthermia with anesthesia	No	Yes
Blood relative with malignant hyperthermia with anesthesia	No	Yes
Pulmonary embolism	No	Yes
Blood clots in legs	No	Yes
Problems with anesthesia	No	Yes

Please describe all **Yes** responses

Eyes		**Circle**
Severe headaches	No	Yes
Double vision	No	Yes
Legally blind	No	Yes
Macular degeneration	No	Yes
Glaucoma	No	Yes
Cataracts	No	Yes

Please describe all **Yes** responses

ENT		**Circle**
Difficult to open mouth sufficiently to interfere with anesthesia	No	Yes
Sinus infections	No	Yes
Balance problems	No	Yes
Hearing loss	No	Yes

Please describe all **Yes** responses

Respiratory		**Circle**
Tuberculosis	No	Yes
Sleep apnea	No	Yes
Chronic cough	No	Yes
Pneumonia	No	Yes
Wheezing	No	Yes
Shortness of breath	No	Yes
Emphysema	No	Yes
Abnormal chest x-ray	No	Yes

Please describe all **Yes** responses

Cardiovascular	**Circle**	
History of rheumatic fever	No	Yes
Heart murmur	No	Yes
Chest pain	No	Yes
Heart attack	No	Yes
Irregular heartbeat	No	Yes
Ankle swelling	No	Yes
Valve replacement	No	Yes
Congestive heart failure	No	Yes

Please describe all **Yes** responses

GU	**Circle**	
Frequent urination at night	No	Yes
Urinary tract infection	No	Yes
Frequency	No	Yes
Pain/burning with urination	No	Yes
Kidney stones	No	Yes

Please describe all **Yes** responses

GI	**Circle**	
Jaundice or hepatitis	No	Yes
Stomach ulcers	No	Yes
Hiatal hernia	No	Yes
Reflux	No	Yes
Heartburn	No	Yes
Blood in stools	No	Yes
Irritable bowel syndrome	No	Yes
Diverticulosis	No	Yes
History of bowel obstruction	No	Yes
Hemorrhoids	No	Yes

Please describe all **Yes** responses

Neurologic	**Circle**	
History of polio	No	Yes
Stroke	No	Yes
Seizures	No	Yes
Neurological problems	No	Yes
Mental health/phobias including anxiety, depression, psychosis, confusion, memory loss	No	Yes
Multiple sclerosis	No	Yes

Please describe all **Yes** responses

Orthopaedic		**Circle**
Back problems	No	Yes
Muscle disorders	No	Yes
Fibromyalgia	No	Yes
Fracture of neck or spine	No	Yes
Arthritis of other joints including hands, wrists, shoulders, elbows, feet, ankles, hips, and knees	No	Yes
Rheumatoid arthritis	No	Yes
Gout	No	Yes
Pseudogout	No	Yes

Please describe all **Yes** responses

Endocrine		**Circle**
Hypoglycemia (low blood sugar)	No	Yes
Thyroid problems	No	Yes
Diabetes	No	Yes

Please describe all **Yes** responses

Hematologic/Immunologic		**Circle**
Hemophilia	No	Yes
Transfusion problems	No	Yes
Bleeding tendency	No	Yes
History of any cancer diagnosis	No	Yes
Anemia	No	Yes

Please describe all **Yes** responses

Other medical problems/comments:

Name:_____ Today's Date:_____ SS#:_____

Past Medical History

Surgeries/Hospitalizations	Year	Reason

Have you ever had general anesthesia? _____No _____Yes
Have any problems with anesthesia? _____No _____Yes Describe:_____

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

_____Work in the home _____Employed (occupation_____) _____Student
_____Single _____Married _____Divorced _____Separated _____Widowed
Children _____No _____Yes #_____
Do you live alone? _____No _____Yes
Exercise? _____Daily _____Weekly _____Monthly _____Rarely _____Never
What type of exercise?_____
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? _____This year _____1 year _____5 years _____10 years
Previously smoked _____Packs per day for_____years.
Drink alcohol? _____Daily _____1-2x/week _____1-2x/month _____1-2x/year

Reviewed By:_____MD Date:_____