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:_____

Salt Lake Orthopaedic Clinic
Brent A. Felix, M.D.
Cervical Triage Form

Date:_____ SSN#:_____

Name:_____ Sex:_____ Marital Status:_____

Date of Birth:_____ Telephone #:_____

Address:_____
Street City State Zip Code

Insurance: 1. Private Insurance_____

2. Workers' Compensation_____

3. Motor Vehicle Accident_____

How did you hear about the Salt Lake Orthopaedic Clinic?

1. Referred by Doctor_____

2. Referred by Emergency Room or Hospital Clinic_____

3. Referred by patient of Salt Lake Orthopaedic Clinic_____

4. Referred by Other_____

5. Referred by Self_____

1. How old are you?_____

2. Are you:
   a. Male
   b. Female

3. Where is your pain?
   a. Neck
   b. Neck and right arm
   c. Neck and left arm
   d. Neck and both arms

4. How long have you had your pain?
   a. A few days
   b. Several weeks
   c. Several months
   d. Several years

5. Is your pain
   a. Intermittent
   b. Constant

6. Has your pain been
   a. Getting worse
   b. Stayed the same
   c. Getting better

7. Where is the pain in your arm?
   a. Entire arm
   b. Back of the arm
   c. Outside of the arm
   d. Inside of the arm
   e. Front of the arm
   f. None

8. How far down your arm does the pain go?
   a. Shoulder
   b. Elbow
   c. Wrist
   d. Hand
   e. Doesn't apply to me

9. If the pain goes into your hand, in which part of your hand does it go?
   a. Entire hand
   b. Thumb
   c. Index finger
   d. Middle finger
   e. Ring finger
   f. Small finger

10. How did your pain begin?
   a. Slow gradual onset
   b. Sudden onset

11. What were you doing at the time your pain began?
   a. Household activities such as vacuuming, raking, child care, etc.
   b. Lifting/bending at work
   c. After falling
   d. In a motor vehicle accident
   e. While playing sports
   f. Of unknown cause

12. From 0 to 10 (0 being no pain and 10 being excruciating pain), what is the average level of your neck pain in the last few days?___

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13. From 0 to 10 (0 being no pain and 10 being excruciating pain), what is the average level of your arm pain in the last few days?___

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14. What percent of your pain is in your neck versus your arm?

	Neck pain	vs.	Arm pain
a.	100%		0%
b.	90%		10%
c.	80%		20%
d.	70%		30%
e.	60%		40%
f.	50%		50%
g.	40%		60%
h.	30%		70%
i.	20%		80%
j.	10%		90%
k.	0%		100%

15. Is the pain worse with
   a. Standing
   b. Sitting
   c. Walking
   d. Laying down

16. Is the pain best with
    a. Standing
    b. Sitting
    c. Walking
    d. Laying down

17. What activities make your pain worse?
    a. Coughing and sneezing
    b. Bending forward
    c. Lifting
    d. Lying down
    e. Any activity in general

18. Do you have numbness in your arm?
    a. No numbness in your arm
    b. Numbness in the same distribution as the pain
    c. Numbness in the back of the arm
    d. Numbness in the front of the arm
    e. Numbness in the inside of the arm

19. Do you have numbness in your hand?
    a. No numbness in the hand
    b. Numbness in the same distribution as the pain
    c. Numbness in the entire hand
    d. Numbness in the top of hand
    e. Numbness in the outside of hand
    f. Numbness in the inside of hand
    g. Numbness in the bottom of hand

20. Do you have weakness in your arm?
    a. No weakness
    b. Weakness in the entire arm
    c. Weakness in the shoulder
    d. Weakness in the elbow
    e. Weakness in the wrist

21. Have you had changes in your bowel and bladder habits?
    a. No change in bowel and bladder habits
    b. Increased frequency in urination
    c. Constipation
    d. Diarrhea
    e. Difficulty controlling urine/stool

22. Have you tried bed rest for your pain?
    a. No
    b. Yes

23. Which pain medications have you tried for your pain?
    a. No pain medications
    b. Lortab
    c. Percocet
    d. Advil/Motrin/ibuprofen
    e. Naprosyn
    f. Ultram
    g. Oxycontin
    h. Tylenol #3
    i. Darvocet
    j. Relafen
    k. Celebrex
    l. Vioxx
    m. Tylenol
    n. Other

24. When was the last time you visited a physical therapist for your neck/arm pain?
    a. Have never visited a physical therapist for this pain
    b. A few days ago
    c. Several weeks ago
    d. Several months ago
    e. Years ago

25. How many times have you visited a physical therapist for your neck/arm pain?
    a. Never visited a physical therapist
    b. 1-2
    c. About 5-10
    d. About 10-20
    e. Over 20

26. How many times have you visited a chiropractor for this pain?
    a. No visits
    b. 1-2 visits
    c. About 5-10 visits
    d. About 10-20 visits
    e. Over twenty

27. Have you tried acupuncture?
    a. Not tried
    b. Tried

28. How many epidural steroid injections have you tried?
    a. 1 epidural injection
    b. 2 epidural injections
    c. 3 epidural injections
    d. 4 epidural injections
    e. More than 5 epidural injections
    f. Zero

29. What other treatments have you tried?
    a. Facet injections
    b. Trigger point injections
    c. Nerve root injections
    d. Massage therapy
    e. TENS unit
    f. Other_____
    g. No other treatment

30. What other studies have you had done?
    a. Bone scan
    b. CT scan
    c. Myelogram
    d. EMG
    e. MRI
    f. X-rays
    g. Blood work

31. How many previous low back surgeries have you had?
    a. Zero
    b. 1
    c. 2
    d. 3
    e. Other_____

32. What, if any, previous back surgery have you had?
   a. No previous surgery
   b. A previous discectomy
   c. Laminectomy/decompression
   d. Cervical fusion
   e. Other_____
   f. Unknown

33. If you have had previous neck surgery, when was it?
   a. No previous surgery
   b. Less than a year go
   c. 1-2 years ago
   d. A few years ago
   e. Over 10 years ago

34. Did the surgery help with your symptoms?
   a. No previous surgery
   b. No help at all
   c. Helped for a short period of time
   d. Helped for quite a while
   e. Not applicable

Medical History

Please place a check by any illness that you have had.

_____Heart murmur
_____Heart attack
_____Other heart disease
_____High blood pressure
_____Blood transfusion
_____Phlebitis
_____Thyroid disorder
_____Venereal disease
_____Nervous disorder
_____Hepatitis
_____Fibromyalgia
_____Migraine headaches
_____Gout
_____Pneumonia
_____Emphysema
_____Allergies (hayfever)
_____Asthma
_____Epilepsy
_____Anemia
_____Tuberculosis
_____Tumor
_____Jaundice
_____TMJ pain
_____Anxiety
_____Glaucoma
_____Bleeding disorder
_____Kidney/Bladder
If yes, what_____
_____Ulcer (peptic, duodenal)
_____Arthritis
_____Diabetes
If yes, how long_____
_____Cancer
If yes, what type_____
_____Depression
_____Other_____

Surgical History

Please place a check by each surgery that you have had.

_____Neck surgery
_____Back surgery
_____Open heart surgery
_____Heart angioplasty
_____Gall bladder removed
_____Appendectomy
_____Hysterectomy
_____Carpal tunnel release
_____Shoulder surgery
_____Other_____
_____Prostate removed
_____Cosmetic surgery
_____Colon surgery
_____Lung surgery
_____Hip replacement
_____Knee replacement
_____Knee arthroscopy
_____Kidney surgery

Medications

Medication	Number of milligrams	How often

Do you have any drug allergies?

a. No
b. Yes

If yes, to which drugs do you have an allergy? Please list.

_____

_____

_____

_____

Family History

Relative	Medical problems	Alive or deceased	Cause of death
Mother			
Father			
Brother			
Sister			
Grandparents			

How much do you smoke?

a. None
b. $^1/_2$ pack per day
c. 1 pack per day
d. 1 $^1/_2$ packs per day
e. 2 or more packs per day

How much alcohol do you drink?

a. None
b. Almost every day
c. Once per week
d. Once per month
e. Rarely

Work Status

What is your present work status?

1. Full duty
2. Part time
3. Light duty
4. Disabled
5. Unemployed
6. Retired

Date last worked?_____

Occupation_____ Employer_____

What is the average weight of objects that you have to lift at work?

1. 1-25 lbs
2. 25-50 lbs
3. 50-75 lbs
4. 75-100 lbs
5. 100 lbs or more

How frequently are you required to lift daily?

1. Rarely
2. Occasionally
3. Frequently
4. Constantly

Are you presently receiving:	Workers' compensation	Yes_____	No_____
	Social Security	Yes_____	No_____
	Private disability	Yes_____	No_____

Are you involved in a personal lawsuit? Yes_____ No_____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o. Please explain any of the Yes answers in the spaces provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other_____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other_____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other_____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other_____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other_____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other_____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other_____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other_____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other_____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other_____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other_____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N
Other_____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other_____		

Psychologic

Are you generally satisfied with your life? Y N

Do you feel severely depressed? Y N

Have you considered suicide? Y N

Other_____

Any other conditions that we should be aware of?

PHYSICIANS USE ONLY: (COMMENTS/NOTES)

Physician:_____ Date:_____