

FRONT RANGE ORTHOPEDIC CENTER PATIENT INFORMATION

Today's Date _____ Family Doctor _____ ID Verified _____

PATIENT (Legal Name) _____

Patient Address _____

Home Phone _____ Cell # _____ Date of Birth _____ Age _____

Patient's Social Security Number _____ - _____ - _____ Male _____ Female _____

Marital Status S M W D Email Address _____ @ _____

Emergency Contact _____ Relationship to Patient _____ Phone _____

How did you learn about Front Range Orthopedic Center (Please indicate all that apply)

_____ Referral from Doctor Dr. _____ referred me

_____ Referred by a family member or friend

_____ Reputation in the community

_____ Website

_____ Insurance

_____ Advertisement

_____ Other, please list _____

If patient is under 21, give name and address of parents

Name _____ Address _____

Parent Social Security Number _____ - _____ - _____

EMPLOYMENT STATUS OF PATIENT OR PARENTS

Employer _____ Phone _____

INSURANCE INFORMATION INDICATE IF NONE _____

Primary Insurance Co _____ Subscriber # _____

Insurance Co Address _____ Group # _____

Policy Holder's Name _____ Date of Birth _____ Male _____ Female _____

Policy Holder's SSN _____ - _____ - _____ Employer _____

Secondary Insurance Co _____ Subscriber # _____

Insurance Co Address _____ Group # _____

Policy Holder's Name _____ Date of Birth _____ Male _____ Female _____

Policy Holder's SSN _____ - _____ - _____ Employer _____

I hereby assign to this medical practice all monies to which I am entitled for medical and/or surgical expenses relative to the service rendered by this practice but not to exceed my indebtedness to said medical practice. It is understood that any monies received from the above named insurance company(s), over and above my indebtedness, will be refunded to me or my insurance company(s), as is determined to be appropriate, when my bill is paid in full. I understand I am financially responsible to said medical practice for charges not covered by this assignment.

Disability Forms In the event that I require that disability forms be completed on my behalf, I request FROC, PC to disclose and all information to persons who administer claims for disability purposes used for evaluating and administering my claims benefits, which may include assisting me in returning to work. **I understand that FROC, PC charges \$20.00 for the completion of each disability form and that fee is to be paid in advance.** The average time of completion of disability forms is 10 to 14 working days.

Insured or Guardians Signature _____

Patient's Signature _____

**FRONT RANGE ORTHOPEDIC CENTER
PATIENT HEALTH QUESTIONNAIRE**

Referring Physician _____ PCP _____
Best Phone # _____ Belongs to _____

Name: _____ DOB: _____ DATE: _____

Date of Injury/Accident: _____ Date Symptoms Began: _____ Type Of Accident: __WC __Auto __Other

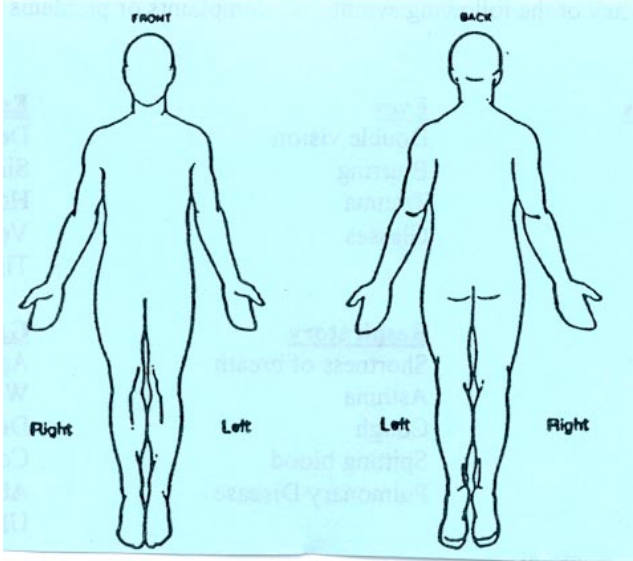
Were X-rays taken? YES NO Where _____ Occupation _____

Work Status: __Regular Duty __Light Duty __Not Working, how long? _____

Have you had any other treatment for this problem? NO YES If yes, please describe _____

Height _____ Weight _____

IF YOU ARE EXPERIENCING ANY PAIN, PLEASE MARK THE LOCATION OF YOUR PAIN ON THE DIAGRAMS BELOW:



1) Social History: (Do you...)	YES	NO
Smoke cigarettes?	0	0
Chew tobacco?	0	0
Consume Drink alcohol at any time?	0	0
Use "street" drugs?	0	0
2) Have you:		
Ever taken Cortisone or steroids?	0	0
Ever received blood transfusions?	0	0
Ever had problems with anesthesia?	0	0
Ever used street drugs?	0	0
3) Known Drug Allergies: If none, please circle NONE		

4) Your Current Medications:(Attach list if appropriate) Include dose and prescribing doctor. Include Over-the-Counter.
If none, please circle NONE.

5) MEDICAL HISTORY:

Past Illness: _____

Conditions currently being treated: _____

Do you have any disabilities? YES NO If, yes, please list: _____

6) All Surgeries: Please provide procedure, date, place, and physician Also, list past injuries / broken bones

PATIENT HEALTH QUESTIONNAIRE (Continued)

7) Family History

Mother _____ Living Age of death _____ Cause of death _____
 Father _____ Living Age of death _____ Cause of death _____
 Family Illnesses (such as diabetes, cancer, arthritis, heart disease, blood disease) _____

8) General / Review of Systems: Please **circle** any of the following symptoms, complaints, or problems you have had recently or in the past. **IF NONE, PLEASE CIRCLE NONE.**

Constitutional Symptoms:

Weight gain Anorexia
 Weight loss Night Sweats
 Malaise Fever
 Fatigue
 Other _____
NONE

Eyes:

Double Vision Vision Loss
 Blurring Cataract
 Contacts Trauma
 Glasses Macular Degen
 Other _____
NONE

Ears, Nose, Throat & Mouth:

Deafness Frequent Sore Throat
 Sinus Pain Frequent Colds
 Hoarseness
 Vertigo
 Tinnitus
 Other _____
NONE

Cardiovascular:

Chest pain Hypertension
 Palpitations Phlebitis (Blood Clot)
 Heart attack Stroke
 Irregular Beats Pacemaker
 Elevated Cholesterol Heart Cath
 Other _____ Heart Stents
NONE

Respiratory:

Shortness of breath Wheezing
 Asthma COPD
 Chronic Cough Sleep Apnea
 Spitting blood On Oxygen
 Pulmonary disease Have you had TB
 Other _____
NONE

Gastrointestinal:

Appetite change Vomiting
 Nausea Rectal Bleeding
 Diarrhea Difficulty Swallowing
 Constipation Abdominal pain
 Ulcers
 Other _____
NONE

Genitourinary:

Hesitancy Urgency
 Incontinence Frequent Urination
 Painful urination
 Menstrual problems
 Possibly Pregnant
 Other _____
NONE

Musculoskeletal:

Fractures Muscle Cramps
 Sprains Muscle Weakness
 Pain Gout
 Swelling
 Arthritis
 Stiffness
 Atrophy
 Other _____
NONE

Skin:

Color change Dryness
 Temperature change Eczema
 Rashes Excessive Sweating
 Lesions Nail Change
 Scars Hair Changes
 Masses
 Other _____
NONE

Neurological:

Speech & swallowing problems Tremor
 Changes in sensations Dizziness
 Seizures Headaches
 Weakness Head Injury
 Balance problems Numbness
 Memory loss Loss of Consciousness
 Coordination problems Concussion
 Other _____
NONE

Psychological:

Depression Anxiety
 Mood changes Delusions
 Hallucinations Fearful
 Sleep Problems Inability to Concentrate
 Other _____
NONE

Endocrine:

Abnormal thirst Cold Intolerance
 Excessive eating Heat Intolerance
 Hyperactivity
 Thyroid disease
 Diabetes
 Other _____
NONE

Hematologic/Lymphatic:

Bleeding tendencies Prolonged Bleeding
 Lymph node pain / enlargement Nose Bleeds
 Anemia Easy Bruising
 Other _____ Hepatitis
NONE

Allergic / Immunologic:

Skin Inflammation
 Hives
 Other _____
NONE

Reviewed by: _____ Date: _____



SUMMARY NOTICES OF PRIVACY PRACTICES

DEAR FROC, P.C. PATIENT,

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). It is the policy of FROC, P.C. to comply with the federal regulations regarding HIPAA, we strongly believe in protecting the confidentiality and security of your health information.

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures.
2. **HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.
3. **YOUR RIGHTS.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. **OUR LEGAL DUTY.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of notice. We may change our privacy practices any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.
5. **PRIVACY COMPLAINTS.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, please contact Jessie Guajardo at 303-772-1600. You may also send a written complaint to the U.S. Department of Health and Human Services. FROC, P.C. can provide you with the appropriate address upon request.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both layers of this Notice of Privacy Practices. Then return this top layer and acknowledgement of receipt to the receptionist.

Signature: _____ Date: _____

Print Patient Name: _____



Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to individuals you must sign this form. Signing this form will only give consent to release this information to the following individuals indicated below. This consent form will not allow FROC, P.C. to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow FROC, P.C. to release my medical and/or billing information to the following individual(s):

- 1. _____ Relation to Patient: _____
- 2. _____ Relation to Patient: _____
- 3. _____ Relation to Patient: _____

Patient Name: _____

Patient Signature: _____ Date: _____

Authorization to Leave Messages with Household Members/Answering Machine

Occasionally it is necessary for the staff of FROC, P.C., to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of FROC, P.C., discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name: _____

Patient Signature: _____ Date: _____

For office use only:
Patient Number: _____