

IDAHO ORTHOPAEDIC & SPORTS CLINIC NEW PATIENT PROFILE

Today's Date _____ Referred by _____
 Patient _____ Sex M F Age _____ Date of Birth _____
 Married Single Widowed Divorced Social Security No. _____
 Address _____ City _____ State _____ Zip _____
 Home Telephone No. _____ Message Telephone No. _____
 Have you, or an immediate family member seen our doctors before? Y N When? _____
 Employer _____ Work Telephone No. _____
 Are you covered by: Health Insurance Y N Medicare Y N Welfare Y N None Y N
 Reason for visit: _____ Right Y N Left Y N
 When did this problem start? _____ Have you had this same problem before? Y N
 Date of Injury _____ On the job injury? Y N Auto Accident? Y N
 How did accident happen? _____ Location/ State of Accident _____
 Who has previously seen you for this problem? _____
 List your Internist or Family Doctor _____

DO YOU NOW, OR HAVE YOU HAD ANY MEDICAL PROBLEMS IN THE PAST? -EXPLAIN

(Such as High Blood Pressure, Diabetes, Thyroid Problem, Heart Trouble, Ulcers, Cancer, Seizures, Blood Clots, Depression, or any other Condition)

PLEASE LIST ANY SURGERIES YOU HAVE HAD, AND THE APPROXIMATE DATES:

PLEASE LIST ALL FRACTURES OR INJURIES:

LIST ALL MEDICATIONS YOU ARE TAKING: (If none, check here) None

CURRENT MEDICATIONS _____ WHAT IS IT TAKEN FOR? _____

Do you have any MEDICATION ALLERGIES? Y N (if yes, please list them) _____

Any OTHER ALLERGIES?

HAVE YOU EVER BEEN TREATED WITH: Digitalis Y N Insulin Y N Steroids Y N Aspirin Y N

Do you Smoke? Y N If yes, how many packs a day? _____

Do you drink Alcoholic Beverages? Y N How much? _____

Relative	Living?	Deceased at What Age?	Cause of Death
Father	<input type="checkbox"/> Y <input type="checkbox"/> N		
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Brothers	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sisters	<input type="checkbox"/> Y <input type="checkbox"/> N		
Children	<input type="checkbox"/> Y <input type="checkbox"/> N		

IN BLOOD RELATIVES, IS THERE ANY HISTORY OF:

Tuberculosis Y N Heart Trouble Y N High Blood Pressure Y N
 Kidney Trouble Y N Birth Defects Y N Diabetes Y N
 Bleeding Tendencies Y N Cancer Y N Mental or Nervous Disorders Y N

Other _____

Idaho Orthopaedic & Sports Clinic New Patient Profile (page 2)

Person Responsible for Account
Employer
Relationship to Patient
Address
City
State
Zip
Social Security No.
Telephone No.
Telephone No.

Your Spouse
Spouse's Employer
Address
City
State
Zip
Telephone No.

Parent or Guardian (If patient is a minor)
Nearest Relative not living at same address
Address
City
State
Zip
Telephone No.

Primary Insurance
Address
City
State
Zip
Telephone No.

Name of Policy Holder
Group No.
Address
Date of Birth
Policy No.
City
State
Zip
Social Security No.
Employer

Secondary Insurance
Address
City
State
Zip
Telephone No.

Name of Policy Holder
Group No.
Address
Date of Birth
Policy No.
City
State
Zip
Social Security No.
Employer

(Please include a copy of Insurance Cards when Possible)

I hereby give approval for photographs to be used for the records and medical teaching purposes.

Y N Signature

I authorize the release of information that may be necessary to request claim reimbursement from any insurance company that I submit a claim.

Y N Signature

I authorize payment directly to Idaho Orthopaedic and Sports Clinic. I understand they will refund any overpayment on my account.

Y N Signature

I UNDERSTAND A **FINANCE CHARGE** IS COMPUTED ON ACCOUNT BILLINGS UNPAID **90 DAYS AFTER FIRST BILLING**.
PERIODIC RATE OF 11/2% PER MONTH. 18% ANNUAL PERCENTAGE RATE.

Signature