1830 FRANKLIN STREET, SUITE 450
DENVER, COLORADO 80218

Phone: 303-321-1333
Toll Free: 888-900-1333
FAX: 303-321-0620
www.western-ortho.com

Patient Information Form

Please complete all information

IF YOU THINK YOU MAY HAVE SEEN ONE OF OUR DOCTORS BEFORE OR WISH TO GIVE YOUR INFORMATION OVER THE PHONE PRIOR TO YOUR APPOINTMENT DATE CALL **303-321-1333.**

DID ANOTHER PHYSICIAN REFER YOU TO OUR OFFICE? ❑ YES ❑ NO	IF YES, REFERRING PHYSICIAN'S NAME, ADDRESS & PHONE	IF NOT PHYSICIAN REFERRED WHO MAY WE THANK FOR REFERRING YOU?

PATIENT'S FULL NAME (LAST, FIRST, M.I.)	PATIENT'S S.S.#	SEX: ❑ MALE ❑ FEMALE	BIRTHDATE	AGE

PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP)	PATIENT'S HOME PHONE	MARITAL STATUS: ❑ MARRIED ❑ DIVORCED ❑ SINGLE ❑ WIDOWED

NEXT OF KIN/SPOUSE (NAME, ADDRESS, PHONE)	MOTHER'S MAIDEN NAME (PRESCRIPTION REFILL SECURITY CODE)

RESPONSIBLE PARTY	RESPONSIBLE PARTY'S RELATION TO PATIENT	RESPONSIBLE PARTY'S ADDRESS AND PHONE

PATIENT'S EMPLOYER	PATIENT'S EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIP) AND PHONE	OCCUPATION

PARENT/SPOUSE EMPLOYER (COMPANY NAME, ADDRESS, PHONE)	OCCUPATION

INJURY OR COMPLAINT	DATE OF INJURY AND CAUSE	PREVIOUS X-RAYS TAKEN – WHERE AND WHEN

Disease History: Do you have or have you had any of the following?

LUNG

- ❑ Bronchitis
- ❑ Emphysema
- ❑ Asthma
- ❑ TB
- ❑ Sinusitis
- ❑ Respiratory Infections
- ❑ Sleep Apnea
- ❑ Smoker
  - Packs per Day __________
  - # of Years __________
- ❑ Former Smoker
  - Year Quit __________

VASCULAR

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Circulatory Problem
- ❑ Heart Disease
- ❑ Sickle Cell
- ❑ Stroke

SYSTEMIC

- ❑ Muscle/Nerve Disease
- ❑ Diabetes
- ❑ Glandular Trouble
- ❑ Hepatitis: ❑ Type A ❑ Type B ❑ Type C
- ❑ Kidney/Bladder Problems
- ❑ Alcohol Use Y / N
  - Amount __________
- ❑ Stomach/Bowel Problem
- ❑ Polio
- ❑ Back/Disc Disease
- ❑ Jaundice
- ❑ Convulsions
- ❑ Headaches
- ❑ Fainting
- ❑ Glaucoma
- ❑ Malignant Hyperthermia (High Fever)
- ❑ HIV Virus/AIDS

Comments: ____

____

Drug History: In the last six months have you taken any of the following drugs?

- ❑ Steroids
- ❑ Birth Control Pills
- ❑ Antibiotics
- ❑ Asthma Medication
- ❑ Anti-Coagulants (blood thinners)
- ❑ Aspirin
- ❑ Arthritis Medication
- ❑ Tranquilizers
- ❑ Narcotics
- ❑ Other ______________________________
- ❑ Insulin or diabetic
- ❑ Thyroid
- ❑ Blood Pressure
- ❑ Heart Medication

Please list your current medications: ______________________________

____

Allergy and Reaction:

- ❑ Narcotics: ______________________________
- ❑ Antibiotics: ______________________________
- ❑ Anesthetics: ______________________________
- ❑ Other Drugs: ______________________________
- ❑ Latex: ______________________________
- ❑ Non-Medical: ______________________________

Have you had any operations within the last six months? ❑ Yes ❑ No Please list: ______________________________

____

Please list the operations you have had during your life: ______________________________

____

Please list the major illnesses you have had during your life: ______________________________

____

INSURANCE INFORMATION

DO YOU HAVE MEDICARE? ❑ YES ❑ NO	MEDICARE ID NUMBER:	DO YOU HAVE MEDICAID? ❑ YES ❑ NO	STATE ID NUMBER
INSURANCE COMPANY: PPO AFFILIATED? ❑ YES ❑ NO	INSURANCE COMPANY'S ADDRESS:	POLICY NUMBER	POLICY OWNER AND OWNER'S RELATIONSHIP TO PATIENT:
IS THE GROUP INSURANCE THROUGH AN EMPLOYER? IF YES, GIVE EMPLOYER'S NAME IF NOT LISTED ABOVE: ❑ YES ❑ NO EMPLOYER:		IF EMPLOYER NOT PREVIOUSLY LISTED, PLEASE GIVE EMPLOYER'S NAME, ADDRESS AND PHONE	
IS PATIENT COVERED BY ANOTHER INSURANCE COMPANY? IF YES, GIVE NAME OF COMPANY: ❑ YES ❑ NO INSURANCE COMPANY:			POLICY NUMBER:

ACCIDENT INFORMATION

IS THIS VISIT DUE TO AN INJURY RESULTING FROM ACCIDENT? ❑ YES ❑ NO	IF YES, HOW DID ACCIDENT OCCUR? (EXPLAIN BRIEFLY)	
WHERE DID ACCIDENT OCCUR?	DATE OF ACCIDENT:	WAS ACCIDENT WORK-RELATED? IF YES, GIVE NAME OF EMPLOYER AT TIME OF ACCIDENT: ❑ YES ❑ NO EMPLOYER:
COMPENSATION CLAIM NUMBER: (IF APPLICABLE)	NAME AND ADDRESS OF COMPENSATION CARRIER:	

IF AUTO ACCIDENT RELATED:	NAME AND ADDRESS OF AUTO INSURANCE CO.: PPO AFFILIATED? ❑ YES ❑ NO	POLICY NUMBER	NAME OF INSURANCE AGENT AND PHONE

Everything stated above is true and complete to the best of my knowledge and I agree to notify you of any changes.

Patient's Signature: ______________________________ Date: ______________