WESTERN ORTHOPAEDICS
1830 Franklin Street, Suite 450
Denver, Colorado 80218

INITIAL PATIENT INFORMATION FORM

Patient Information

Name_____

Address_____

City/ST/Zip _____

Home #_____(Priority 1, 2, or 3)

Work #_____(Priority 1, 2, or 3)

Cell #_____(Priority 1, 2, or 3)

Today's Date _____

Date of Birth_____ Age_____

Height_____ Weight_____

SS # _____Sex: ❑Male ❑Female

Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced

Email Address _____

Sometimes we may need to reach you. By providing your phone numbers and/or email address, you consent to receiving such communications, pre-recorded or otherwise using the information you provided.

Referring Physician Information

Name_____

Address_____

Phone_____ Fax _____

Primary Care Physician Information

Name_____

Address_____

Phone_____ Fax _____

If not physician referred **who may we thank for referring you?** _____

Relationship to referral source: _____

Patient's Employer Information

Name_____

Address_____

Phone_____

Occupation_____

❑Spouse Information ❑Responsible Party Information

Name_____

Address_____

Phone_____

Relationship_____

Who should we contact in case of an emergency? _____

Relationship: _____ Phone: _____

How did you become injured?

❑No Injury
Date of injury (mo/day/year) _____
❑Sports (which sport)_____
❑Motor Vehicle accident ❑Work / Job
Where did injury occur: _____
_____
Briefly describe your injury and what you were doing:
_____
_____
Is there a workers comp claim? ❑Yes ❑No
Is there a medical pay Auto claim? ❑Yes ❑No

Injury continued

How long have you had symptoms? _____
Are you currently working? ❑Yes ❑No ❑Retired

❑Normal Job ❑Limited Duty

Please describe your current job limitations _____
_____

Date stopped work (if applicable) _____

Date returned to work _____

Name: _____ Date of Birth: _____

Insurance Information

Do you have Medicare? Yes ❑ No ❑ Medicare ID#: _____
Do you have Medicaid? Yes ❑ No ❑ State ID#: _____
Insurance Company: _____

Claims Address: _____

ID #: _____ Group #: _____ Copay: _____

Policy Owner: _____ Policy Owner DOB: _____
Policy owner's relationship to patient: _____ Is the group insurance through an employer? _____
If yes, give employers name: _____
Is patient covered by another insurance? Yes ❑ No ❑
If yes, list name and address of insurance company: _____
Is this a work related injury? Yes ❑ No ❑ If yes, please give workers compensation insurance info.:
Name/Address/Phone#/Claim#: _____

_____

Is this an auto related injury? Yes ❑ No ❑ Do you have med pay on YOUR auto policy? Yes ❑ No ❑
If yes, please give auto insurance info. Name/Address/Phone#/Claim# _____
_____

I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

RELEASE OF INFORMATION:

I hereby authorize release of any information acquired in the course of my examination or treatment to my insurance carrier.

Signed: _____ Date: _____
Patient or guardian signature

RELEASE OF BENEFITS:

I hereby authorize my insurance benefits to be paid directly to Western Orthopaedics, P.C. I understand I am responsible for all non-covered services.

Signed: _____ Date: _____
Patient or guardian signature

FINANCIAL AGREEMENT:

I the undersigned, individually obligate myself to the payment of my Western Orthopaedics, PC account incurred by the patient's service(s). I understand that I will be responsible for charges not covered by my health insurance carrier(s). I will be expected to pay my medical bill in full when I am discharged or at the time of provision of medical services, diagnostic services and/or procedures, unless I have made other arrangements with Western Orthopaedics, PC's financial department. Should these bills not be paid, I understand that my account and any of my healthcare information necessary for collection of the bill will be referred to an attorney or collection agency. I will be responsible for paying all attorneys' fees, court costs, and other legal fees, collection agency fees, and costs incurred in collecting my medical payment, together with late fees and interest at the maximum rate allowable by law.

Disclosure

I have read and understand these documents and accept and agree to follow the conditions contained therein.

Signed: _____ Date: _____
Patient or guardian signature