WESTERN ORTHOPAEDICS
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: _____

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1830 Franklin Street, Suite 450
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James C. Holmes, M.D.
Timothy J. Birney, M.D.
Edward H. "Ted" Parks, M.D.
Armodios M. Hatzidakis, M.D.
Rajesh Bazaz, M.D.
Kevin K. Nagamani, M.D.
Brian J. White, M.D.
Steven M. Traina, M.D.
Thomas G. Mordick II, M.D.

Name of Patient:_____ Account #:_____

Patient Date of Birth:_____

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, 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. I also understand that certain health information may be released to state and/or other federal agencies for reporting purposes unless otherwise stated below.

Signed: _____ Date:_____
Patient or guardian signature

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Name of Patient:_____ Account #:_____

Patient Date of Birth:_____

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received or read a copy of Western Orthopaedics, PC's Privacy Practices with the effective date of April 14, 2003.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Documentation of Good Faith Efforts to obtain patient's acknowledgment that they received Western Orthopaedics, PC's Notice of Privacy Practices:

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

Signature of Employee Completing Form: _____

Date Signed: _____

DATE: ____ / ____ / _____ NAME: _____ MRN: _____

For the following questions, please indicate what percent satisfaction you have regarding ***BOTH*** of your ***SHOULDERS***

0% = TERRIBLE/Not satisfied at all 100% = GREAT/Completely satisfied

(Or ***choose A NUMBER between 0 and 100*** to show your satisfaction)

1. How satisfied are you with the ***comfort (lack of pain)*** in your shoulder ***at rest***?
   Right [ ] % Left [ ] %
2. How satisfied are you with the ***comfort (lack of pain)*** in your shoulder ***during or after activity***? (e.g. work, school, chores, sports)
   Right [ ] % Left [ ] %
3. How satisfied are you with your ability to ***sleep through the night*** without your shoulder bothering you?
   Right [ ] % Left [ ] %
4. How satisfied are you with the ***mobility ('range-of-motion')*** of your shoulder?
   Right [ ] % Left [ ] %
5. How satisfied are you with the ***stability (how secure it feels in its socket)*** or your shoulder?
   Right [ ] % Left [ ] %
6. How satisfied are you with the ***strength*** of your shoulder?
   Right [ ] % Left [ ] %
7. How satisfied are you with your shoulder's ability to do ***your regular chores and/or everyday activities***?
   Right [ ] % Left [ ] %
8. How satisfied are you with your shoulder's ability to do ***your regular work activities***? (write N/A if you do not work/are retired)
   Right [ ] % Left [ ] %
9. How satisfied are you with your shoulder's ability when you do ***your regular fitness/exercises/sports***? (write N/A if you do not do/play)
   Right [ ] % Left [ ] %
10. How satisfied are you ***with getting through the day and not feeling worried or frustrated*** about your shoulder?
    Right [ ] % Left [ ] %

Thank you for completing this questionnaire!

OFFICE USE ONLY
RIGHT:
□ Non-Operative
□ Pre-Operative
□ Post-Operative
Date of Sx:
_____
Procedure:
_____

LEFT:
□ Non-Operative
□ Pre-Operative
□ Post-Operative
Date of Sx:
_____
Procedure:
_____

Dr. Hatzidakis Follow Up Form

*TODAY's DATE:*_____

PATIENT INFORMATION (please fill out before your visit): *Your Primary Care MD* _____

Name: _____ *Age:*_____ *Any changes in medical history?* _____

Which shoulder / elbow bothers you today (circle)? RIGHT LEFT BOTH NEITHER

How has your shoulder / elbow progressed since last visit? BETTER WORSE SAME Percent of normal? _____%

Where is your shoulder pain located? BACK FRONT SIDE DEEP ARM ARMPIT _____

How would you describe the pain? ACHING BURNING SHARP DULL IRRITATING _____

How is the pain RANGE, on a scale of 0 (no pain) to 10 (worst pain ever)? _____

How long does the pain last, and when does it occur? _____

What is your pain AT REST, on a scale of 0 to 10? _____ *With activity?*_____

What makes the pain better? _____ *Worse?* _____

What medicines are you taking for the pain, and how much/often? (Please list all specific medicines and doses)

_____

Any numbness or tingling? If yes, where? _____ *Any fevers, night sweats or chills?* _____

Any other comments or things we should know? _____

_____

Your signature and date please: _____

PHYSICIAN / PA EXAMINATION (for physician only)

___A&O x 4, appropriate, ambulates normally. ____ Skin no lesions / signs infection / incisions healed / sut removed

R L B Elbow / Wrist / Finger AROM full without crepitation/weakness/instability R L B Fingers NVI M/S M/R/U

R L B Elbow AROM/PROM Flexion-Extension Arc _____ PRON_____ SUP_____

R L B Shoulder AROM full without crepitation/weakness/instability with exception of _____

R L B Shoulder AROM/PROM FF_____ AB_____ ER0_____ IR_____

R L B Tenderness at ACJ LHB LT GT None ____Relocation ____Apprehension ___O'Brien ___LO ___BP

R / L / B Sh Strength testing (out of 5) FF_____ AB_____ JobesAB_____ ER0_____ IR_____

OTHER FINDINGS _____

NOTES: _____

Imaging: _____

A/P_____F/U_____

Approximately _____ minutes or longer was spent with the patient today, over half of this time was spent counseling the patient regarding their findings and options for treatment

Provider Signature/Date: _____