

Park City:
2200 Park Ave. Bldg D. Suite 100
Park City, UT 84060
Tooele:
2356 N 400 E, Bldg B, Suite 102
Tooele, UT 84074
Old Mill Medical Center:
6360 South 3000 East, Suite 210
Salt Lake City, UT 84121



HEIDEN ORTHOPEDICS

Eric Heiden, MD
Daniel Gibbs, MD
Karen Heiden, MD
Richard Zipnick, MD
Jason Dickerson, DPM
Enrique Feria-Arias, MD
Lindsey Marshall, PA-C
Whitney Schroder, PA-C

Patient Health History/Subjective Information

Legal First Name _____ Legal Last Name _____ Middle Initial _____ Birth Date ____/____/____ Age _____

Pharmacy Preference _____ Pharmacy Address _____ Fax Number _____

Reason for today's visit: _____ Dominant Hand: Left Right

How long have you been experiencing these problems? _____ Current Weight _____ Lbs. Current Height _____' _____"

Please List Any Medications You Are Currently Taking, Including Over-The-Counter Medications, Vitamins, etc.

Name of Medication	Dosage	How Often Taken	Are You Allergic to Any Medications?	
			Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, please list them below.
			Name of Medication	Type of Reaction
USE SECOND PAGE IF NEEDED				

Hospitalizations, Surgeries or Serious Illnesses	Date

Rate your pain by marking 0-10 on the scale below.
Zero (0) = No pain and Ten (10) = Extremely Intense Pain
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Treatments Attempted	No Relief	Good Relief	
Bed Rest			
Physical Therapy			
Chiropractic			
Home Exercise or Home Health Service			
Heat or Cold Therapy			
Wearing a Sling, Brace or Orthotics			
Spinal or Muscle Injections			
TENS Unit			

Have you ever had any problems with Anesthesia?
Yes No If yes, please list problems below

General Medical History				
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers or GI Bleeding	<input type="checkbox"/> Pregnant
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver or Kidney Disease	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Weight Loss/Gain
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression	<input type="checkbox"/> Circulation Problems

Review of Systems: Check all that apply				
HEENT:	GI:	CV:	EXTREMITIES/MUSCULOSKELETAL:	HEMATOLOGY
<input type="checkbox"/> Difficulty Seeing	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Anemia
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Blood clot
<input type="checkbox"/> Change in Vision	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Chest Pain on Exertion	<input type="checkbox"/> Diminished range of motion	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Dark/tarry stools	RESPIRATORY:	<input type="checkbox"/> Swelling	<input type="checkbox"/> Easy Bleeding
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Nausea	<input type="checkbox"/> Cough	<input type="checkbox"/> Pain	NEUROLOGY:
<input type="checkbox"/> Sore throat	ENDOCRINE:	<input type="checkbox"/> Pain with breathing	GU:	<input type="checkbox"/> Headache
<input type="checkbox"/> Runny nose	<input type="checkbox"/> Intolerant to Heat	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Migraines
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Intolerant to Cold	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Seizures
PSYCH	<input type="checkbox"/> Osteoporosis	SKIN:	<input type="checkbox"/> Urinate Frequently	<input type="checkbox"/> Stroke
<input type="checkbox"/> Depression	<input type="checkbox"/> Osteopenia	<input type="checkbox"/> Rash	<input type="checkbox"/> Awake at Night to Urinate	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Legions	NECK:	<input type="checkbox"/> Numbness
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Lumps	<input type="checkbox"/> Neck or Thyroid Enlargement	<input type="checkbox"/> Weakness
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Unusual Weight Gain	<input type="checkbox"/> Sores	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Unusual Weight Loss	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Other	<input type="checkbox"/> Other

Social History	
Do you Use Tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/> Packs per day _____ For how long _____ Quit date _____	Drink Alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/> How many drinks per day _____ How many drinks per week _____ Type (beer, Wine, Liquor, etc.) _____ Quit date _____

ADDITIONAL MEDICATIONS:

Name of Medication	Dosage	How Often Taken

Signature _____ Date _____



Date: _____

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Patient Demographics

Legal First Name _____ Legal Last Name _____ Middle Initial _____ Birth Date _____ / _____ / _____

Billing Address _____ Apt. # _____ City _____ State _____ Zip _____

Main Phone # _____ type (Circle One): Cell Home Work Additional Phone # _____ type (Circle One): Cell Home Work

Social Security # _____ Email Address _____

*Primary care physician _____ Race/Ethnicity _____

Work Status: Working Unemployed Stay at home parent Retired Student Disabled _____

Employer: _____ Employer Phone: _____ Contact: _____

<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Male
<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Female
<input type="checkbox"/> Divorced	<input type="checkbox"/> DP	<input type="checkbox"/> Transgender

Emergency Contact Information

Contact Name _____ Contact Phone # _____ Relationship to Patient _____

Contact Address _____ Apt. # _____ City _____ State _____ Zip _____

Responsible Party (if under 18 years of age)

Responsible Party's Legal Name _____ Birth Date _____ Relationship to Patient _____

Responsible Party's Address _____ City _____ State _____ Zip _____ Phone # _____

Insurance Information

Primary Insurance Company _____ Policy/Claim # _____ Group# (If applicable) _____ Effective date _____ / _____ / _____

Policy Holder's Name (If not self) _____ Policy Holder's Birth Date _____ Relationship to Patient _____

Secondary Insurance Company _____ Policy/Claim # _____ Group# (If applicable) _____ Effective date _____ / _____ / _____

Secondary Insurance Policy Holder's Name _____ Policy Holder's Birth Date _____ Relationship to Patient _____

Adjuster Name (If workers compensation claim) _____ Adjuster Phone # _____ Adjuster Fax _____

How did you hear about us? Please be specific:

Family or Friend _____

Internet (Please list Website/source) _____

Referring Physician (Please print name) _____

Print Ad (Please list where you saw the ad) _____

Other (please explain) _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Name of patient: _____

I understand the email and/or phone number provided by me to Heiden Orthopedics may receive appointment reminders, updates about products and services, promotions, special offers, news & events. We will treat your data with respect and do not share your information with third party advertisers.

The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) of 1996 was created with the sole purpose and goal of protecting patient's medical records and financial information. We will not share this information without your consent. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I (patient/parent/guardian) authorize the staff of Heiden Orthopedics to release any:

FINANCIAL INFORMATION MEDICAL INFORMATION

to the following people:

1. _____ 2. _____

Heiden Orthopedics will not release my medical information to individuals without a signed release form.

Signature _____ **Date** _____

FINANCIAL CONSENT

Payment in full is due within sixty (60) days from the date of service. If payment in full is not made as required, then in addition to all other amounts that may be due I agree to pay a collection fee of up to 40% of the principal amount as provided by section 12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection (whether incurred by Heiden Orthopedics or it's assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre and post-judgement). Any interest due hereunder shall be calculated at a rate equal to 18% per annum and may, as determined by Heiden Orthopedics or its assigns: (a) accrue on some or all amounts due and (b) compound as frequently as daily – meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period.

I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone numbers) provided to Heiden Orthopedics by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Heiden Orthopedics or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of a automated dialing device and/or the use of text messages – some or all of which may result in data charges. I also consent to receiving e-mails under the same terms at any e-mail address provided by me or anyone associated with me or acting on my behalf. In granting each and all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.

Signature _____ **Date** _____