HEIDEN ORTHOPEDICS

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.

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Name of Medication	Dosage	How Often Taken	Are You Allergic to Any Medications?	
			Yes☐ No☐ If yes, please list them below.	
			Name of Medication	**Type of Reaction**
USE BACK OF PAGE IF NEEDED				

Hospitalizations	Date

Surgeries	Date

Rate your pain by marking 0-10 on the scale below.

Zero (0) = No pain. Ten (10) = Extremely Intense Pain

0-----1-----2-----3-----4-----5------6------7-----8-----9-----10

Have you ever had any problems with Anesthesia?

Yes☐ No☐ If yes, please list problems below

Family Medical History						
☐ Father	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Mother	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Sibling	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Children	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Grandparent	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other

General Medical History				
☐ Heart Disease	☐ Cancer/Tumor	☐ Asthma	☐ Ulcers	☐ GI Bleeding
☐ High Blood Pressure	☐ Diabetes	☐ HIV/AIDS	☐ Liver Disease	☐ Pacemaker
☐ Heart Murmur	☐ Arthritis	☐ Hepatitis	☐ Kidney Disease	☐ Epilepsy
☐ Fibromyalgia	☐ Scoliosis	☐ Emphysema	☐ Thyroid Disorder	☐ Osteoporosis
☐ Bleeding Disorder	☐ Tuberculosis	☐ Stroke	☐ Depression	☐ Circulation Problems

Serious Illness not listed above? Yes ☐ No ☐
Illness type _____
For how long _____

Are you currently pregnant or breastfeeding?
Breastfeeding? Yes ☐ No ☐
Pregnant? Yes ☐ No ☐
How far along? _____

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

Social History	
Tobacco Use? Yes ☐ No ☐	Alcohol Use? Yes ☐ No ☐
Packs per day _____ For how long _____	How many drinks per day _____ For how long _____
Type (cigarettes, vaping, chew, etc.) _____	Type (beer, wine, liquor, etc.) _____
Quit date _____	Quit date_____

Recreational Drug Use? Yes ☐ No ☐
Frequency _____ For how long _____
Type _____
Quit date _____

Recreational Activities or Hobbies (Please list)

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			
Topical Creams (CBD, THC, etc.)			

Signature _____ **Date** _____

HEIDEN ORTHOPEDICS

Date: _____

Patient Demographics

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

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

___-___-_____ ___-___-_____
Main Phone # type: ☐ Cell ☐ Home ☐ Work | Additional Phone # type: ☐ Cell ☐ Home ☐ Work

___-___-____ _____
Social Security # | Email Address

_____ _____
*Primary care physician | Race/Ethnicity

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ DP

☐ Male ☐ Female ☐ Transgender

Work Status: ☐ Working ☐ Unemployed ☐ Stay at home parent ☐ Retired ☐ Student ☐ Disabled_____

Employer: _____ Employer Phone: _____ Contact: _____

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) _____

HEIDEN ORTHOPEDICS

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 _____