Eric Heiden, M.D.
Karen Heiden, M.D.
Becky Sullivan, PA

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.

.

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**
Are you taking a GLP-1 (Ozempic, Trulicity)? Yes No				
Type:				
Are you taking blood thinners? Yes No				
Type:				

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
☐ Heart attack	☐ Tuberculosis	☐ Stroke	☐ Depression	☐ Circulation Problems

Have you had a:	Are you currently	Do you have a history of:
☐ Deep Vein Thrombosis (DVT) ☐ Pulmonary Embolism (PE) ☐ MRSA infection When_____	☐ Pregnant ☐ Breastfeeding How far along? _____	☐ Bleeding Disorders ☐ Autoimmune Disorder Type_____

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	Serious Illness not listed above? Yes No ☐	
☐ Alcohol Addiction	☐ Unusual Weight Loss	☐ Psoriasis	Illness Type_____	
			For how long _____	

Social History	
Tobacco Use? Yes ☐ No ☐ Packs per day _____For how long _____ Type (cigarettes, vaping, chew, etc.) _____ Quit date _____	Alcohol Use? Yes ☐ No ☐ How many drinks per day _____For how long _____ Type (beer, wine, liquor, etc.) _____ Quit date_____
Recreational Drug Use? Yes ☐ No ☐ Frequency_____For how long_____ Type_____ Quite Date_____	Do you have any of the following ☐ Living Will ☐ Advance Directive ☐ Power of Attorney

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 _____

SALT LAKE OFFICE
6360 S 3000 E
Ste 210
Cottonwood Heights,
UT 84121

PARK CITY OFFICE
2200 Park Ave
Bldg D, Ste 100
Park City, UT 84060

HEBER CITY OFFICE
1716 N US-40
Ste 201
Heber City, UT 84032

HEIDEN ORTHOPEDICS
PHONE: 435-615-8822 FAX: 435-615-8823

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Name of Patient: _____

The purpose of this 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.

RELEASE OF INFORMATION:

I authorize Heiden Orthopedics to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

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 disclose your medical information without written permission.

Signature: _____ **Date:** _____

BENEFIT ASSIGNMENT AND FINANCIAL CONSENT

Agreement of Responsibility: I understand that COPAYMENT IS DUE AT THE TIME OF SERVICE (coinsurance and deductibles may also be collected at the time of service). I accept financial responsibility for any non-covered or denied charges and for co-pays, deductibles, and coinsurance not covered by my insurance including those for durable medical equipment. Durable medical equipment may include braces, splints, orthotics, crutches, or other types of rehabilitative equipment.

Late payment charge: I understand and agree that if I fail to pay my account bill or any monies due and owing Heiden Orthopedics by the scheduled due date, Heiden Orthopedics will assess monthly service charges on the past due portion of my account until my past due account is paid in full.

Collection agency fees: I understand and agree that if I fail to pay my account bill or any monies due and owing Heiden Orthopedics by the scheduled due date and fail to make acceptable payment arrangements to bring my account current, Heiden Orthopedics may refer my delinquent account to a third-party collection agency. I further understand and agree that I am responsible for paying the collection agency fee, which may be based on a percentage at a maximum of thirty-three percent (33%) of my delinquent account, together with all costs, and expenses, including reasonable attorney's fees and court costs, necessary for the collection of my delinquent account. Finally, I understand and agree that my delinquent account may be reported to one or more of the national credit bureaus.

Assignment of Benefits: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider of practice for services rendered.

I hereby consent to be contacted by phone at any number, including wireless ones, provided to Heiden Orthopedics. Calls may be made by Heiden Orthopedics or its affiliates, agents, contractors, or assigns, including billing companies or third-party collection agencies, using pre-recorded or artificial voice messages, automated dialing devices, or text messages. I also consent to receive emails under the same conditions at any email address provided. I acknowledge my responsibility for maintaining my privacy.

Patient Name, Please Print

Last Name:_____ **First Name:**_____ **DOB:** _____

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) _____