



**PATIENT INFORMATION**

NAME (LAST): \_\_\_\_\_ (FIRST): \_\_\_\_\_ (M.I.) \_\_\_\_\_

MAILING ADDRESS (STREET): \_\_\_\_\_

(CITY) : \_\_\_\_\_ ( STATE): \_\_\_\_\_ (ZIP): \_\_\_\_\_

PHONE # (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_ (CELL): \_\_\_\_\_

MAY WE LEAVE A MESSAGE?  YES  NO

EMAIL: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SEX: F / M SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMERGENCY CONTACT (LAST): \_\_\_\_\_ (FIRST): \_\_\_\_\_  
(PHONE) : \_\_\_\_\_ ( RELATIONSHIP): \_\_\_\_\_

PRIMARY CARE PHYSICIAN (NAME): \_\_\_\_\_  
(ADDRESS) : \_\_\_\_\_ ( PHONE#): \_\_\_\_\_

PHARMACY (NAME): \_\_\_\_\_ (LOCATION): \_\_\_\_\_

DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

**IF YOU ARE A MINOR:**

PARENTS/GUARDIANS (NAME): \_\_\_\_\_

(ADDRESS): \_\_\_\_\_

PHONE # (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_ (CELL): \_\_\_\_\_

**IF YOU ARE A STUDENT:**

SCHOOLS (NAME): \_\_\_\_\_ (PHONE #): \_\_\_\_\_

(ADDRESS): \_\_\_\_\_

COACHES NAME/#: \_\_\_\_\_

ATHLETIC TRAINERS NAME/#: \_\_\_\_\_

INSURANCE:  ANTHEM/ BC/BS  CIGNA  HARVARD PILGRAM  AETNA  MVP  
 MEDICARE  MEDCAID  TRICARE  OTHER: \_\_\_\_\_  
 SELF PAY (UNINSURED)

**WORKERS COMPENSATION (ONLY IF APPLICABLE)**

EMPLOYER(NAME): \_\_\_\_\_ (PHONE): \_\_\_\_\_ (FAX): \_\_\_\_\_

(MAILING ADDRESS): \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ CASE MANAGER/CONTACT: \_\_\_\_\_

(MAILING ADDRESS): \_\_\_\_\_

(PHONE): \_\_\_\_\_ (FAX): \_\_\_\_\_ (CLAIM#): \_\_\_\_\_



Medical History

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pain (circle): 0 1 2 3 4 5 6 7 8 9 10

Occupation: \_\_\_\_\_ Hobbies/Interests/Sports: \_\_\_\_\_

ALLERGIES (please list all):

Empty box for listing allergies

REVIEW OF MEDICAL HISTORY

Grid of medical history checkboxes including Staph History, Poor Healing, Cancer/Tumor, etc.

MEDICATIONS (please list all):

Table with columns: NAME, DOSE, FREQUENCY

\*Add additional medications on back side

PAST SURGERIES (include ~ month/year):

Table with columns: MONTH/YEAR, PROCEDURE

Tobacco Use: [ ] Y Packs per day: \_\_\_ # Years: \_\_\_ [ ] N [ ] Quit x \_\_\_ years

Alcohol Use: [ ] Y Type: \_\_\_\_\_ Frequency: \_\_\_ drinks \_\_\_ # per week [ ] N

Family History (check all that apply):

Table for family history with columns: Mother, Father, Mother's Mother, Mother's Father, Father's Mother, Father's Father

NOTES:

Large empty box for notes



**THE ALPINE CLINIC PATIENT CONSENT**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**AGREEMENT TO PAY FOR NONCOVERED SERVICES**

By signing below, you as the patient/patient guardian, are solely responsible for contacting your insurance company for a determination of benefits. All of the medical professionals associated with this practice are specialists, therefore requiring a referral from your primary care physician in most instances. You are financially responsible for all specialist copayments and deductibles incurred at the time of your visit(s). Patients are also fully responsible for any out-of-network or noncovered costs.

I understand and consent to the statement above. Initials: \_\_\_\_\_

**CONSENT FOR HEALTH CARE**

(Please see front desk for a copy of the consent policy.)

By signing below, I certify that I have read the CONSENT FOR HEALTH CARE form (or had it read to me), that I understand and agree to all terms unless otherwise noted, and that I am the patient or patient's legal representative with authority to sign this document on behalf of the patient.

I understand and consent to the statement above. Initials: \_\_\_\_\_

**THE ALPINE CLINIC SERVICES**

To comply with the Patient Protection and Affordable Care Act, at the time of your MRI or Physical Therapy referral, it is your right to know that Alpine Clinic MRI and Alpine Physical Therapy is owned by The Alpine Clinic. You are not required to receive MRI or Physical Therapy services from Alpine Clinic MRI or Alpine Physical Therapy. You may choose to receive MRI or Physical Therapy services anywhere. In order to provide you with MRI and Physical Therapy choices, please see the list, which gives you the names and locations of several MRI and Physical Therapy providers throughout the region.

I understand and consent to the statement above. Initials: \_\_\_\_\_

**PRESCRIPTION HISTORY CONSENT**

I authorize The Alpine Clinic to view and obtain my external prescription history via eClinicalWorks. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time several years ago. My signature certifies that I have read and understand the scope of my consent and I authorize the access.

I understand and consent to the statement above. Initials: \_\_\_\_\_

**HIPAA-  
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I request the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_

I understand and consent to the statement above. Initials: \_\_\_\_\_

**ELECTRONIC MEDICAL RECORDKEEPING**

I understand that The Alpine Clinic utilizes electronic medical records as a resource to store and retrieve my medical records. These records are encrypted and kept in a secure location, which are accessible only by the providers and staff members of The Alpine Clinic. I understand that there is password protected access to these records. My signature certifies that I understand that The Alpine Clinic will utilize an electronic medical record and I consent to this use.

I understand and consent to the statement above. Initials: \_\_\_\_\_

By signing below, I acknowledge and consent to the statements above.

Patient Name (printed): \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IF UNDER AGE 18 YEARS OLD ONLY**

Guardian Name (printed): \_\_\_\_\_ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_