THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ Sex ☐ M ☐ F

Race _____ Ethnicity _____ Language _____

Cell Phone _____ Work Phone _____ Home Phone _____

Fax _____ E-mail Address _____

Permanent Mailing Address _____

City _____ State _____ Zip _____

Occupation _____ Retired? ☐ Y ☐ N

Marital Status ... Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Relative to Contact in Case of Emergency _____

(A relative not living with you)

Relationship _____ Phone _____

Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How were you referred to us? _____

INJURY INFORMATION

Date of Injury _____ Work Related: ☐ No ☐ Yes Auto Accident: ☐ No ☐ Yes

What is Injured? _____

Describe Injury _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Sex ☐ M ☐ F

Employer _____ Occupation _____

SECONDARY INSURANCE COMPANY:

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Sex ☐ M ☐ F

Employer _____ Occupation _____

WORKMAN'S COMPENSATION INSURANCE:

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Claim Number _____ Case Worker's Name _____

Case Worker's Phone Number _____ Fax _____

Employer at Time of Injury _____

Address _____

Patient _____ Date _____

Responsible Party _____ Date _____

UNACCOMPANIED MINOR WAIVER

This section is required to be signed by a parent or legal guardian in order for an unaccompanied minor to be seen by any physician or clinical staff at The Steadman Clinic. By signing, you (parent/guardian) agree that The Steadman Clinic may evaluate and treat the unaccompanied minor in whatever way is medically necessary.

Parent/Guardian Signature: _____ ***Date:*** _____

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.

INITIAL EVALUATION FORM

Peter J. Millett, M.D., M.Sc.
Shoulder, Knee, Elbow Surgery / Sports Medicine
The Steadman Clinic

NAME: _____

Age: _____ **Today's Date:**_____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us?
If yes, please give name / address of the person/physician:

_____

Occupation? _____

Where is your problem? (please circle)

Shoulder Knee Elbow

Neck Back Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please check all that apply):

- Pain
- Weakness
- Instability / giving way / dislocation?
- Stiffness?
- Swelling?
- Other _____

How did you injure yourself?

- No injury
- Sports (which sport?)_____
- Motor vehicle accident
- Work / job –

Is there a workers comp claim? Yes / No

Sports level: none / recreational / college / professional

Date of injury?_____

How long have you had symptoms?
_____ Days _____ Mos. _____ Yrs.

Please briefly describe the injury:

_____

_____

Diagnosis (if you know or have been told)?

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)

_____

_____

How severe is the pain? ***(0 = none, 10 = severe pain)***

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired

☐ Normal job? ☐ Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any previous imaging studies?

X-rays	No / Yes	date:_____
MRI	No / Yes	date:_____
CAT scan	No / Yes	date:_____

PAST MEDICAL HISTORY:

- ❑ High blood pressure _____
- ❑ Heart problems _____
- ❑ History of Heart attack_____
- ❑ Stroke _____
- ❑ Seizures _____
- ❑ Asthma _____
- ❑ Gastritis _____
- ❑ Kidney disease _____
- ❑ History of Cancer _____
- ❑ Osteoporosis _____
- ❑ History of blood clot/embolus_____
- ❑ Blood clotting disorder_____
- ❑ Diabetes _____
- ❑ History of skin infections_____MRSA_____
- ❑ Other _____

_____

MEDICATIONS: (please list all medications you are currently taking)

_____

_____

_____

ALLERGIES:

Are you allergic to Latex ❑ Yes ❑ No

Allergies to Medications? ❑ None _____

SOCIAL HISTORY:

Marital Status: _____

Residency: _____

Alcohol use: ❑ Daily ❑ Socially ❑ Never Tobacco use: ❑ Yes ❑ No

FAMILY HISTORY: (please list diseases that run in your family)

_____

Family history of blood clots _____ Bleeding disorders_____

REVIEW OF SYSTEMS:

1. CONSTITUTIONAL ❑ None ❑ Recent weight change ❑ Chills ❑ Fever ❑ Weakness/Fatigue
   GENERAL ❑ _____

2. EYES ❑ None ❑ Vision change ❑ Glasses/Contacts ❑ Cataracts ❑ Glaucoma
   ❑ Other_____

3. EARS, NOSE, THROAT ❑ None ❑ Loss of hearing ❑ Ear ache or infection ❑ Ringing in ear ❑ Hoarseness
   ❑ Other_____

4. CARDIOVASCULAR ❑ None ❑ Chest Pain ❑ Swelling in legs ❑ Shortness in breath ❑ Palpitations
   ❑ Other_____

5. RESPIRATORY ❑ None ❑ Shortness of breath ❑ Wheezing/Asthma ❑ Frequent Cough
   ❑ Other_____

6. GASTROINTESTINAL ❑ None ❑ Heartburn ❑ Acid Reflex ❑ Nausea or vomiting ❑ Abdominal Pain
   ❑ Other_____

7. MUSCULOSKELETAL ❑ None ❑ Arthritis / joint stiffness ❑ Muscle aches ❑ Swelling of joints
   ❑ Other_____

8. SKIN ❑ None ❑ Rash ❑ Ulcers ❑ Abnormal scars ❑ Sores
   ❑ Other_____

9. NEUROLOGICAL ❑ None ❑ Headaches ❑ Fainting/blackouts ❑ Numbness, tingling, loss of sensation in any part of body ❑ Dizziness
   ❑ Other_____

10. PSYCHIATRIC ❑ None ❑ Depression ❑ Nervousness ❑ Anxiety ❑ Mood Swing
    ❑ Other_____

11. ENDOCRINE ❑ None ❑ Excessive thirst or hunger ❑ Hot/cold intolerance ❑ Hot Flashes
    ❑ Other_____

12. HEMATOLOGICAL ❑ None ❑ Easy Bruising ❑ Easy Bleeding ❑ Anemia
    ❑ Other_____

Signature:_____ Date:_____

Name:_____

THE STEADMAN CLINIC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Location: 181 West Meadow Drive, Ste 400, Vail, Colorado 81657 | T 970.476.1100 | F 970.479.5835
Email: medicalrecords@thesteadmanclinic.com | **Hours of Operation:** 8 a.m. - 5 p.m. Monday - Friday

Patient Information:

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____) _____ Alias: _____ Email: _____

I direct and hereby authorize The Steadman Clinic to deliver or communicate the Protected Health Information specified in this authorization to myself and the party or parties specified in the following medium:

☐ Landline ☐ Message on Voicemail ☐ Cell Phone ☐ Message on Voicemail ☐ Text Message ☐ E-mail ☐ Fax ☐ Mail

I request my protected health information (PHI) to be used or disclosed to the following person, class of persons, or organization:

☐release of medical records ☐ verbal discussion ☐ no records sent at this time please keep

Name: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____

I request my protected health information (PHI) to be released from my medical record(s): (Please check all that apply or describe the information specifically).

☐ Discharge Summary ☐ Discharge Instructions ☐ History and Physical ☐ ER Record ☐ Medication Records ☐ Lab Report ☐ Treatment Plan ☐ Clinic Note ☐ Consultation ☐ Operative Report ☐ Pre-Operative ☐ Notes EKG / ECG ☐ CD of images
☐ Provider's Name: _____
☐ Other: _____
☐ Specific Date(s): _____ to _____ **or if no dates are specified, the last two (2) years will be released.**

I authorize the release of information in my health record which may include information related to:

☐ Behavioral or Mental Health Issues ☐ Sexually Transmitted Diseases ☐ Sexual Assault Nurse Examiner Reports
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus
☐ (HIV) Alcohol and Drug Treatment

Purpose for requesting information: (Please check one)

☐ Request of Patient ☐ Continuation of Care ☐ Other: _____

By signing this authorization, I understand that:

- The authorization form is in effect until revoked by me, or until any records retention period applicable to my records has expired, whichever is sooner.
- Electronic media and delivery methods such as e-mail, or text messages, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of TSC/SPRI. I agree to assume such risks personally, and to hold TSC/SPRI harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing TSC/SPRI to transmit or deliver such information electronically.
- My refusal to sign this form will not adversely affect my ability to receive health services, reimbursement for services and an enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature. I acknowledge the information disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer protected by Federal Law.
- I have the right to revoke this authorization by written notice to TSC/SPRI. I understand actions taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.
- There may be costs associated with this request in compliance with State copying laws.

Patient/Authorized Representative* Signature:_____ Date:_____

Printed Name of Authorized Representative:_____ Relationship to Patient:_____

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

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Directions – The Steadman Clinic Vail Location
181 West Meadow Drive, Suite 400
Vail, CO 81657
Phone: (970) 476-1100

From Denver (East) to Vail (West)

Exit the Denver International Airport and take Pena Boulevard to Interstate 70 heading West. Follow Interstate 70 West approximately 120 miles to Vail, Exit 176. Follow the roundabout half-way around and exit in the direction of Vail Village (under the Interstate). Enter the second roundabout and exit at the second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Valley Medical Center. Parking attendants are available for drop-off assistance and valet parking upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.

From Eagle (West) to Vail (East)

Exit the Eagle County Airport onto Cooley Mesa Road going East. At the stop light turn right (East) on Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Enter the roundabout and exit at the second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Valley Medical Center. Parking attendants are available for drop-off assistance and valet parking upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.