THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date______________________________

Patient Name ____
Last First (Legal) Middle Initial Nickname

Date of Birth ________________ Age__________ SS# _________________________ Sex M ☐ F☐

Race________________Ethnicity________________________Language_______________________________

Cell Phone ___________________ Work Phone __________________ Home phone __________________

Permanent mailing address ____

City ________________________________State __________________ Zip___________________

Email address _______________________________ Occupation _______________________________

Marital Status ___________Spouses Full Name _________________________ Phone __________________

Contact In Case of Emergency ____

Relationship _____________________________ Phone ____

Primary Physician _______________________________ Phone _________________________________

Address _____________________________ City _________________ State ____________ Zip ____________

How were you referred to us?

Medical Professional ☐ Family / Friend ☐ Internet/Website ☐ Other ☐ _________________________

Referral Name ______________________________________ City / State / Zip ________________________

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

Name: ____

Age: __________ Today's Date: ___________________

Date of Birth: _________________________________

Height: _____________ Weight: ________________

Name/Address of Referring Physician:

____

____

Current Occupation:

____

Where is your problem? (please circle)

Shoulder Knee Elbow

Neck Back Other

Side: Left / Right / Both

Dominant Arm: Left / Right

Problem: (check all that apply)

- ☐ Pain
- ☐ Weakness
- ☐ Instability / giving way / dislocation
- ☐ Stiffness
- ☐ Swelling
- ☐ Other ________________________________

How did you injure yourself?

- ☐ No injury
- ☐ Sports (specify) __________________________
- ☐ Motor Vehicle Accident
- ☐ Work/Job

Workers Comp claim: Yes / No

Sports Level: None / Recreational / College / Pro

Date of Injury: __________________________________

How long have you had symptoms?

____

Briefly describe injury: _________________________

____

Diagnosis (if known): ___________________________

____

Previous non-surgical treatments: (meds, physical therapy, injections, bracing)

____

____

Previous surgery for this problem (with dates)

____

____

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

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

Pain at night: Yes / No

Pain wakes you from sleep: Yes / No

Are you currently working? Yes / No / Retired

Job duties level: Normal / Limited

Interested in surgery: Yes / No / Unsure

What makes your problem better?

____

____

What makes your problem worse?

____

____

Describe your current limitations:

____

____

Previous imaging studies for this problem:

X-rays	Yes / No	Date:_________
MRI	Yes / No	Date:_________
CT	Yes / No	Date:_________

MEDICAL HISTORY:

- ☐ High blood pressure ______________________
- ☐ Heart problems __________________________
- ☐ Heart attack ____________________________
- ☐ Stroke ______________ ☐ Seizures______________
- ☐ Asthma ______________ ☐ Gastritis ______________
- ☐ Kidney disease ___________ ☐ Cancer ______________
- ☐ Osteoporosis ____________________________
- ☐ History of blood clot/embolus _______________
- ☐ Blood clotting disorder ____________________
- ☐ Diabetes _______________________________
- ☐ History of skin infections __________________
- ☐ MRSA ________________________________

MEDICATIONS: (please all current medications)

____
____
____

ALLERGIES: Allergic to latex: Yes / No
Allergies to medications: None / ____

SOCIAL HISTORY: Marital Status: ________________ Residency: ______________________________
Alcohol use: Daily / Socially / Never Tobacco Use: Yes / No / Former

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

____
____

Family history of blood clots: Yes / No ___________ Family history of bleeding disorders: Yes / No ___________

REVIEW OF SYSTEMS: (circle all that apply)
1. CONSTITUTIONAL/GENERAL: None / Recent weight change / Chills / Fever / Weakness or fatigue

____

2. EYES: None / Vision change / Glasses or contacts / Cataracts / Glaucoma / Other

____

3. EARS, NOSE, THROAT: None / Hearing loss / Earache or infection / Ringing in ear / Hoarseness / Other

____

4. CARDIOVASCULAR: None / Chest Pain / Swelling in legs / Shortness of breath / Palpitations / Other

____

5. RESPIRATORY: None / Shortness of breath / Wheezing or asthma / Frequent cough / Other

____

6. GASTROINTESTINAL: None / Heartburn / Acid reflux / Nausea or vomiting / Abdominal pain / Other

____

7. MUSCULOSKELETAL: None / Arthritis or joint stiffness / Muscle aches / Swelling of joints / Other

____

8. SKIN: None / Rash / Ulcers / Abdominal Scars / Sores / Other

____

9. NEUROLOGICAL: None / Headaches / Fainting or blackouts / Dizziness /
Numbness, tingling, loss of sensation in any part of the body / Other

____

10. PSYCHIATRIC: None / Depression / Nervousness / Anxiety / Mood swings / Other

____

11. ENDOCRINE: None / Excessive thirst or hunger / Heat or cold intolerance / Hot flashes / Other

____

12. HEMATOLOGICAL: None / Easy bruising / Easy bleeding / Anemia / Other

____

Signature: ______________________________ Date: ____________________

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: (_____) _________________ Fax: (____) __________________ 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 ☐ ER Record ☐ Treatment Plan ☐ Operative Report CD of images
☐ Discharge Instructions ☐ Medication Records ☐ Clinic Note ☐ Pre-Operative
☐ History and Physical ☐ Lab Report ☐ Consultation ☐ Notes EKG / ECG
☐ 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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