



Office Use Only PT Acct # _____
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Health History Form

Name: _____ DOB: _____ Today's Date: _____

List all past medical problems:

List all current medical problems:

Are you currently pregnant or do you think you are pregnant? Yes No

List all current medications:(including over-the-counter and herbal/supplements) _____

What medications have you tried in the past: _____

List all DRUG ALLERGIES including adverse reactions: _____

Review of Systems

Are you currently having or have you had problems with your:

	Check		Describe all yes responses
Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ears, Nose, Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Lungs, Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Digestion/Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bowel movement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bladder problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart problems/Chest Pain (including rheumatic fever)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding problems/Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Balance problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Numbness/tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Blackout/fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Psychological problems/Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
AIDS/Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis/rheumatoid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Weight loss/weight gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Migraines or headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Skin, e.g., rashes, lesions, moles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____



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Past Surgical History

Have you ever had any problems with anesthesia? Yes No Explain: _____

Surgery	Year	Complications

Family History

Do any of your grandparents, parents, siblings, or children have any of the following diseases? Please explain.

- Diabetes Yes No _____
- High blood pressure Yes No _____
- Heart attack Yes No _____
- Cancer Yes No _____
- Arthritis Yes No _____
- Rheumatoid arthritis Yes No _____
- Back or neck problems Yes No _____
- AIDS/HIV Yes No _____
- Bleeding disorders Yes No _____
- Epilepsy Yes No _____
- Hepatitis Yes No _____
- Migraines/headaches Yes No _____
- Psychiatric problems Yes No _____
- Stomach Yes No _____
- Thyroid problems Yes No _____

Social History

- Marital status: Single Married Divorced Separated Widowed
- Do you live alone? Yes No
- Employed (occupation _____) Student Retired
- Children? Yes No Number: _____
- Exercise? Never Rarely Weekly Daily
- What type of exercise? _____
- Smoking? Yes No _____ Packs per day for _____ years.
- Quit smoking? Yes No When? _____
- Previously smoked? Yes No _____ Packs per day for _____ years.
- Chew tobacco? Yes No How much? _____
- Drink alcohol? Yes No How much and how often? _____
- Substance abuse? Yes No What? _____

Patient Signature _____ Date _____

Reviewed by _____ Date _____

MD Signature _____ Date _____



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Durango Orthopedics Associates, P.C.

Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Durango Orthopedic Associates, P.C.

2. **Authorization for Release or Information:** Durango Orthopedic Associates, P.C. and my physician may release information from my medical records to any health care provider involved in my care and treatment, including Mercy Medical Center. Durango Orthopedic Associates, P.C. and my physician may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Durango Orthopedic Associates, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.

3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Durango Orthopedic Associates, P.C. and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Durango Orthopedic Associates, P.C., I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Durango Orthopedic Associates, P.C.

4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Durango Orthopedic Associates, P.C. charges.

5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Durango Orthopedic Associates, P.C. and my physician for charges not paid.

I acknowledge that:

I have read this form and understand its contents

I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms

I am responsible for the payment and/or co-payment that is due at the time of service

Signature of Patient or Legally Responsible Person

Name (Print)

Relationship/Reason Why Patient is Unable to Sign

Date