WELCOME TO COLORADO SPRINGS ORTHOPAEDIC GROUP

We are looking forward to your visit with us. Enclosed is some of our paperwork which we require from you prior to you being seen. Please complete all of the information, at your leisure, and submit them online at www.csog.net, via fax or bring them with you to your appointment in our office.

PLEASE BE SURE TO ALSO BRING A COPY OF YOUR INSURANCE CARD(S) WITH YOU TO YOUR APPOINTMENT. IF YOUR INSURANCE REQUIRES ANY TYPE OF REFERRAL, WE ASK THAT YOU CONTACT YOUR PRIMARY CARE PHYSICIAN TO BE SURE THAT YOUR REFERRAL IS BEING PROCESSED; WE WILL HAVE TO HAVE THE REFERAL BEFORE YOU CAN BE SEEN IN OUR OFFICE.

Please plan to arrive at least 15 minutes prior to your appointment time so that we can upload your paperwork. If you paperwork is not completed, please be here 45 minutes prior.

An initial evaluation at an orthopaedic specialist can last much longer than a typical doctor's appointment, so please leave room in your schedule for this.

Sincerely yours,

The Staff of the Colorado Springs Orthopaedic Group

Enclosures

Colorado Springs Orthopaedic Group
6011 East Woodmen Road, #120 – Colorado Springs, CO 80923

Date: _____ Dr. to be seen: _____

PLEASE COMPLETE THE ENTIRE FORM

Patient Name: _____ M.I. _____ Age: _____
Address: _____
City, State, Zip: _____ _____
Home Phone: (_____) _____ - _____ Date of Birth: ____/____/_____
Social Security #: _____ - ____ - _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

PATIENT'S EMPLOYER INFORMATION:
Employer's Name: _____ Work Phone: (_____) _____ - _____
Address: _____ City, State, Zip: _____
☐ Parent ☐ Spouse's Name (Please Check): _____
Parent or Spouse's Employer: _____
Address: _____ City, State, Zip: _____

Who referred you to our office: _____
Who is your primary care physician (PCP): _____ Phone: (_____) _____ - _____
Does your insurance require a referral? ☐ Yes ☐ No Do you have your referral? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____ - _____
Besides yourself, who may we speak to about your medical condition?:
Name: _____ Relationship: _____ Phone: (_____) _____ - _____
Besides yourself, who may we speak to about your medical billing questions?
Name: _____ Relationship: _____ Phone: (_____) _____ - _____
May we leave messages on your **Home** phone? ☐ Yes ☐ No Phone: (_____) _____ - _____
Work phone? ☐ Yes ☐ No Phone: (_____) _____ - _____
Cell phone? ☐ Yes ☐ No Phone: (_____) _____ - _____

INSURANCE INFORMATION:
(Our receptionist will require a copy of your insurance card(s). Patients with No Insurance or Private Insurance are required to make payment arrangements at the time of service.) INS CO requires the birth date of the subscriber.
Is this claim work related? ☐ Yes ☐ No **Auto accident?** ☐ Yes ☐ No

Primary Insurance:
Name of Company: _____ Phone: (_____) _____ - _____
Address: _____ City, State, Zip: _____
Policy Holder Name: _____ Date of Birth: ____/____/_____ **SocSec #**: _____ - ____ - _____
Relationship to patient: _____ Group Name and/or #:_____
Member ID/Policy #: _____ ☐ HMO ☐ EPO ☐ PPO
Secondary Insurance: Name of Company: _____ Phone: (____) _____ - _____
Address: _____ City, State, Zip: _____
Policy Holder Name: _____ Date of Birth: ____/____/_____ **SocSec #**: _____ - ____ - _____
Relationship to patient: _____ Group Name and/or #: _____
Member ID/Policy #: _____ ☐ HMO ☐ EPO ☐ PPO
Is a referral required? _____Do you have the referral? _____ Is Ins Secondary to Medicare? _____

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Your reason for seeing the doctor? _____

Date of injury: _____ Where & how did the injury occur? _____

X-rays date taken: _____ Where x-rays were taken: _____

Hobbies: _____ Sports/Exercise: _____

Occupation: _____ Previous Occupations: _____

Length of Employment: _____ Last day worked and why? _____

Days missed in last month for medical reasons: _____

Cigarettes: ☐ None OR ☐ Packs per day ___ X ___ Yrs. Alcohol: How often/How much: _____

Injury is related to:
☐ Auto
☐ Work
☐ 3rd Party
☐ None

PERSONAL HISTORY: ILLNESS YOU HAVE HAD

Arthritis	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	**INJURIES: HAVE YOU HAD**			
Polio	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No	Broken/Cracked Bones	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Sprains	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	Seizures	☐ Yes	☐ No	Lacerations	☐ Yes	☐ No	
Pneumonia	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Dislocations	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Concussion	☐ Yes	☐ No	
Chest Pain	☐ Yes	☐ No	Jaundice/Hepatitis	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No	
Heart Attack	☐ Yes	☐ No	Gallbladder	☐ Yes	☐ No	**SURGERY: HAVE YOU HAD**			
High Blood Pressure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	Tonsillectomy	☐ Yes	☐ No	
Arteriosclerosis	☐ Yes	☐ No	Hiatal Hernia	☐ Yes	☐ No	Appendectomy	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No	Carpal Tunnel	☐ Yes	☐ No	
Blood Clots	☐ Yes	☐ No	Nephritis	☐ Yes	☐ No	Arthroscopy	☐ Yes	☐ No	
Bleeding Disorder	☐ Yes	☐ No	Bladder Infections	☐ Yes	☐ No	Knee Surgery	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No	Rashes/Hives	☐ Yes	☐ No	Back	☐ Yes	☐ No	
AIDS/HIV	☐ Yes	☐ No	Eczema	☐ Yes	☐ No	Other	☐ Yes	☐ No	

FAMILY HISTORY: State which blood relative has/had the following and "N/A" if not applicable to you.

Height: _____ *Weight*: _____ *Blood Pressure*: _____

Arthritis: _____ Diabetes: _____ Epilepsy: _____

Cancer: _____ Heart Trouble: _____ Nervous Disorders: _____

Tuberculosis: _____ High Blood Pressure: _____ Anesthesia Problems: _____

Stroke: _____

DO YOU HAVE OR HAVE YOU HAD WITHIN PAST YEAR:

Joint Pains	☐ Yes	☐ No	Earaches	☐ Yes	☐ No	Nausea or Vomiting	☐ Yes	☐ No	
Swelling of Joints	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No	Recurrent Stomach Pain	☐ Yes	☐ No	
Muscle Spasms	☐ Yes	☐ No	Nosebleeds	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No	
Weakness	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Pain Urinating	☐ Yes	☐ No	
Tingling Hands or Feet	☐ Yes	☐ No	Enlarged Glands	☐ Yes	☐ No	Blood in Urine	☐ Yes	☐ No	
Loss of Sensation in Hands or Feet	☐ Yes	☐ No	Night Sweats	☐ Yes	☐ No	Frequent Urination	☐ Yes	☐ No	
			Frequent Infections	☐ Yes	☐ No	Change in Skin	☐ Yes	☐ No	
Trembling of Extremity	☐ Yes	☐ No	Chest Pain	☐ Yes	☐ No	Change in Hair Texture	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No	Pain in Arm	☐ Yes	☐ No	Changes in Weight Anxiety	☐ Yes	☐ No	
Blurred Vision	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Sadness	☐ Yes	☐ No	
Double Vision	☐ Yes	☐ No	Chronic/Frequent Cough	☐ Yes	☐ No				
Spots before Eyes	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No				

I have been made aware of the privacy policies of Colorado Springs Orthopaedic Group, and have received (or made available to me) a copy of the Notice of Privacy Practices of Colorado Springs Orthopaedic Group.

Signature: _____ Date: _____

Colorado Springs Orthopedic Group

(719) 574-8383

Please complete this form regarding the reason you are seeing the doctor today.

What date did this problem or issue start: _____

Patient Name:_____ DOB:_____
Dominant Hand:_____ Gender:_____

1. What part of the body is injured/painful?_____
2. Did an injury occur? ☐ YES ☐ NO
3. Was the injury work related? ☐ YES ☐ NO
4. Describe the injury? _____
_____
5. What are the symptoms (i.e. Pain, instability, weakness, looseness)?
_____

_____
6. Where exactly is your pain (ie.front, back, top, side)?_____
7. Describe your pain (i.e. Sharp, dull, stabbing, aching)?_____
8. What activities make your symptoms worse?_____

_____

_____

9. How long have you had these symptoms? _____
10. Have you had problems with this part of your body in the past? ☐ YES ☐ NO
11. Have you had problems with your opposite side? ☐ YES ☐ NO
12. What have you done for your symptoms (circle and describe positive responses)?
    a. Medications: _____
    b. Activity modifications: _____
    c. Physical therapy: _____
        1. When? _____
        2. With who(m)? _____
        3. How long? _____
13. Have you had surgery for this problem in the past? ☐ YES ☐ NO
14. If stated yes to surgery, when did it occur? _____
15. Who did the surgery? _____
16. What exactly was done?
_____

_____

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MEDICATION QUESTIONNAIRE

Patient Name: _____ Date: _____

Are you currently taking any pain medications or narcotics? ☐ Yes ☐ No
What pain medications or narcotics are you taking? _____
Who is the physician ordering these medications? _____

Are you *allergic* to any medications? ☐ Yes ☐ No
Name of medication: _____

Do you have a history of substance abuse? ☐ Yes ☐ No

Name and Location (or phone number) of your pharmacy: _____

Patient Signature: _____ Date: _____

MEDICATION LIST
(Please include Vitamins and Herbal Supplements)

Name of Medication	Strength/Dosage	Reason for Medication

FOLLOWING TO BE COMPLETED BY PHYSICIAN OFFICE
Medication ordered by Dr. _____

_____	Refills: _____
_____	Refills: _____
_____	Refills: _____
_____	Refills: _____
_____	Refills: _____
_____	Refills: _____