Coal Creek Medical Plaza
1032 South 88th St.
Louisville CO 80027
303-665-0286

BOULDER BONE & JOINT ORTHOPEDIC URGENT CARE

Michael P. Wertz, M.D.
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BCH Foothills Campus
4820 Riverbend Rd.
Boulder, CO 80301
303-449-4545

Patient name_____ DOB_____ Date _____

Employer/School_____ Position/Grade_____

Problem

Current Problem? _____
_____
_____

Date this problem started_____

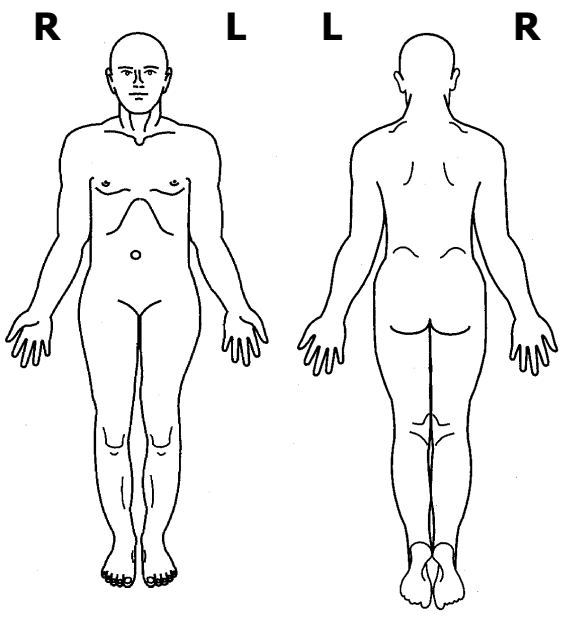
Is this work related? _____

How did problem occur/start_____
_____
_____

Treatments you have received for this problem _____
_____
_____

Seen in ER?(if yes name)_____ X-Rays/MRI Taken?(where)_____
Auto Accident?_____ Pending litigation?_____
Who referred you to or how did you hear about our office:
_____

Mark Injury Location



Name_____**Date**_____

Surgical History (any surgery, not just orthopedic surgery)

Problem + Date or Age	***Treatments + Doctor***	**Successful (Y/N)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History Height_____Weight_____

Are you pregnant?_____

List any current or past medical problems (dates and Doctors)

_____
_____
_____
_____

Current Medications (Prescription, Over the Counter, Herbal health products,vitamins, or dietary supplements)

Name	**Dose**	**Frequency**	**Name**	**Dose**	**Frequency**
1. _____			**6.** _____		
2. _____			**7.** _____		
3. _____			**8.** _____		
4. _____			**9.** _____		
5. _____			**10.** _____		

All Medications written and called in from this office will be done so during normal business hrs (8am-5pm) Mon-Fri. Please contact the pharmacy first when requesting a new prescription or prescription refill. Please give our office 24 hours to refill your prescription.

Allergies to MEDICATIONS (list medication and reaction)

_____
_____
_____

How often do you smoke (packs per day) _____Are you a former smoker_____
How often do you drink alcohol (glasses per week) _____
How often do you use recreational drugs (per week) _____

Thank you for filling out this form

Family Physician _____

Thank you for filling out this form

2017

WELCOME TO THE OFFICE OF
BOULDER BONE AND JOINT
(Please fill out COMPLETELY, print and sign at the bottom)

PATIENT INFORMATION

Name_____Today's Date: _____
Last First Middle

Permanent Mailing/Parent
Address_____
Street Apt. City State Zip

Date of Birth _____ Age____ Social Security# _____

Female ___ Male ___ Minor____Single____ Married____ Widowed____Other_____

Race (Circle one) White Black / African American Asian Hispanic

Home Phone _____ Secondary Phone_____

E-Mail Address _____

If under 21, parents name_____ Phone _____

Employer _____Business Phone _____

Emergency Contact_____ Phone _____
(Not living with patient)

Primary Physician _____ Phone _____

MEDICAL INSURANCE INFORMATION (PLEASE FILL OUT COMPLETELY)

Primary Insurance Co._____**Tricare Sponsor#**_____

Policy Holder **-** _____**Self** _____**Spouse** _____**Parent** ____**Guardian**

Policy Holder Name:_____**DOB:**_____**Employer:**_____
(If different from patient)

Secondary Insurance Co._____

Policy Holder - _____**Self**_____**Spouse**_____**Parent**_____**Guardian**

Policy Holder Name (If different from patient) _____

Authorization: I certify to the accuracy of the above listed information. I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to the provider of services. I understand I am financially responsible to Boulder Bone and Joint for charges not covered or denied by my insurance company. Boulder Bone and Joint is not party to any legal agreements between divorced or separated parents. I further agree, in the event of my non-payment, to the collection agency cost and/or court costs and/or attorney fees and reasonable fees should this be required. A copy of this authorization may be treated as an original.

Insured/Patient's Signature _____ Date: _____

If minor (17 or younger), parent or legal guardian must sign
Parent or legal guardian _____Relationship _____

Printed name of parent or legal guardian _____

Michael P. Wertz, M.D.
Sports Medicine
Hand Surgery
Orthopedic Surgery

J. David Grauer, M.D.
Sports Medicine
Orthopedic Surgery

James G. Reid, M.D
Orthopedic Surgery
Upper Extremity/Hand Surgery
Reconstructive Microsurgery

Jeffrey R. Gagliano, M.D
Sports Medicine
Orthopedic Surgery

REFERRALS

If your insurance company requires a referral for you to see a specialist, you must obtain one from your primary care physician prior to your appointment. It is your responsibility to find out if a referral is required; our office staff will not be checking this information.

The referral must be logged in the insurance company's system in order to be effective. A handwritten or faxed referral from your primary care physician does not mean that the insurance company has it on file.

If you do not take the necessary steps to ensure the referral is on file with your insurance company, any visits that are denied will be your responsibility.

_____
Initials

NO SHOW / BILLING POLICY

This is to inform you that Boulder Bone and Joint/Orthopedic Urgent Care has a no show policy. If you do not keep your regular scheduled physician or therapy appointment, you will be charged $40.00 for the missed appointment. YOU WILL BE RESPONSIBLE FOR THIS CHARGE as insurance companies do not pay for no-shows.

_____
Initials

HIPAA

I hereby acknowledge that I have received Boulder Bone and Joint's Notice of Privacy Practices. (attached to clipboard - copy available upon request)

_____
Initials

I have read and understand/agree to all of the above.

_____ _____
Patient's Name **Date of Birth**

_____ _____
Signature of Patient or Patient Representative **Date**

_____ _____
Printed Name if signed on behalf of Patient **Relationship to Patient**