2021

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/Parent
Address_____
Street Apt. City State Zip

Date of Birth _____ Age_____ SSN_____

Female _____ Male _____ Minor ____ Single ____ Married ____ Widowed ____ Other_____

Race (circle one): White Black / African American Asian Hispanic

Home Phone_____ Cell Phone _____

E-Mail Address _____

If under 21, parents name _____ Phone _____

Employer _____ Business Phone _____

Emergency Contact _____ Phone _____

Preferred Pharmacy _____
(Include address)

Primary Physician _____ Phone_____

Referring Physician _____

MEDICAL INSURANCE INFORMATION (Please Fill Out Completely)

Primary Insurance Co _____ ID #: _____

Tricare Sponsor # _____
(Military Members Only)

Policy Holder : Self Spouse Parent Guardian
(Circle one)

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

Secondary Insurance Co._____ ID #: _____

Policy Holder : Self Spouse Parent Guardian
(circle one)

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 _____

Name_____ **Date**_____

Family History:

Please list any medical history or conditions in your siblings, parents or grandparents (for example heart or lung disease, diabetes, cancer, blood clots, bleeding disorders, stroke/seizures, arthritis or osteoporosis):

_____

_____

_____

Review of Systems: (circle any conditions or symptoms that YOU currently have or have had in the past)

General: None Weight loss Insomnia Chronic fatigue

Other:_____

Eyes/Ears/Nose/
Throat: None Vision change Glasses/contacts Cataracts Glaucoma
Hearing loss or ringing Breathing difficulty Sinus problems

Other:_____

Cardiovascular None Chest pain Leg swelling Hypertension Palpitations
High cholesterol Other:_____

Respiratory None Asthma Wheezing Frequent cough Pneumonia

Other:_____

Gastrointestinal None Indigestion/Acid reflux Ulcers Abdominal pain GI/Stomach bleed

Other:_____

Musculoskeletal None Arthritis Muscle weakness Joint pain Back pain

Other:_____

Skin None Rash Ulcers Scars Cancer Other:_____

Neurological None Headaches Seizures Numbness Dizziness

Other:_____

Psychiatric None Depression Anxiety Other psych diagnosis:_____

Endocrine None Diabetes Hypo-/Hyperthyroid Hot flashes Other:_____

Hematology None Blood clots Excessive Bleeding Anemia Easy Bruising

Other:_____

BCH Foothills Campus
4820 Riverbend Rd.
Boulder, CO 80301
303-665-0286

BOULDER BONE & JOINT ORTHOPEDIC URGENT CARE

Michael P. Wertz, M.D.

Jeffrey Gagliano, M.D.

Patient name_____ DOB_____ Date _____

Employer/School_____Position/Grade_____

Problem

Current Problem?_____

Date this problem started_____

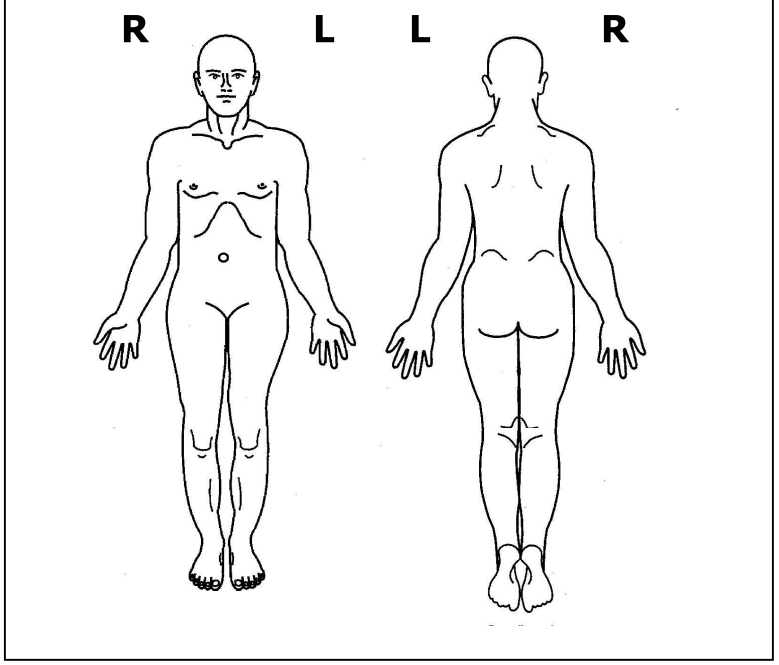
Is this work related? _____ Dominant Hand **R** **L**

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) _____

Family Physician _____

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

Jeffrey R. Gagliano, M.D
Sports Medicine
Shoulder Surgery
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, or fail to cancel at least 24 hours in advance, 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. Boulder Bone and Joint will send out statements for any outstanding balances due.

_____
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**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we leave a voicemail at home or on your cell phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(Print Name Please)

Signature: _____ Date: _____