Please complete forms and fax to 208-345-9514 in advance of your appointment. Forms will be signed at your appointment
ISMI 1188 University Dr Boise, ID 83706 208-336-8250 Toll free 877-420-4862

ISMI IDAHO SPORTS™ MEDICINE INSTITUTE

Office use only G L M S

DATE: _____

REFERRED BY: _____
(MD/Coach/Trainer/Friend, etc.)

PATIENT:_____
(LAST NAME) (FIRST NAME) (M.I.) (NICKNAME)

PATIENT ADDRESS: _____CITY: _____STATE: ___ZIP: _____

DOB: _____ AGE: _____SEX: ____M ____F Social Security Number # _____

HOME PHONE: _____CELL PHONE: _____ WORK PHONE: _____

PATIENT EMPLOYER: _____

PATIENT/GUARDIAN'S EMAIL ADDRESS: _____
(EMAIL MUST BELONG TO PATIENT IF 18+ YEARS OF AGE OR PARENT/GUARDIAN IF MINOR)

PATIENT IS A STUDENT: ____N/A _____ Full-time _____ Part-time

MARITAL STATUS: _____ SPOUSE'S NAME: _____SSN: _____ DOB: _____

SPOUSE'S Employer: _____ SPOUSE'S Cell#: _____ SPOUSE'S Work #: _____

HOW YOU WOULD LIKE RECEIVE APPOINTMENT REMINDERS ☐Cell Call ☐Cell Text ☐EMAIL ☐ Home phone

*PREFERRED LANGUAGE: _____ *ETHNICITY: ☐Hispanic or Latino ☐ Non-Hispanic or Latino

*RACE: ☐American Indian OR Alaska Native ☐Asian ☐Black/African American ☐White ☐Native Hawaiian or Pacific Islander ☐Other _____

Must be completed if patient is a child or covered under another person's insurance.

Father: _____DOB: _____ SSN: _____ Employer: _____

Address: _____ City: _____ State: _____Zip: _____
Indicate if same as patient or please complete address line above.

Cell phone: _____ Work phone : _____

Mother: _____DOB: _____ SSN: _____ Employer: _____

Address: _____ City: _____ State: _____Zip: _____
Indicate if same as patient or please complete address line above

Cell phone: _____ Work phone : _____

Other Insured: _____DOB: _____ SSN: _____ Employer: _____

Address: _____ City: _____ State: _____Zip: _____
Indicate if same as patient or please complete address line above

CONTACT IN CASE OF EMERGENCY: _____ Relationship: _____ Phone: _____

Insurance Information – Bring your Insurance Cards and Identification Front/Back of insurance card(s) is required at time of service*

Insurance Company Name/Address	Policy ID# Group#	Policy Holder/Subscriber Name	Relationship
Insurance Company Name/Address	Policy ID# Group#	Policy Holder/Subscriber Name	Relationship
Workman's Compensation or Car Insurance	**Claim #**	**Claim address**	**Agent or Representative**

I _____ have completed the information above. Date: _____

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REVIEW OF SYSTEMS

Name: _____**DOB:** _____ **Date** _____ **Height:** _____ **Weight:**_____

Chief complaint/ Reason for visit: ☐R ☐L_____

How severe is the pain on a scale of 1-10? ☐ No pain ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10 ☐ Severe

Type of pain (check all that apply): ☐Sharp ☐Dull ☐Pins/Needles ☐Aching ☐Cramping
☐Stabbing ☐Throbbing ☐Constant ☐Intermittent **Duration of pain:** _____

Is your current problem the result of an injury?
☐No ☐Yes, if so, how did it happen? Check all that apply below:
☐Car Accident ☐Work Accident ☐Other _____**Date of Injury:** _____

Pharmacy and location: _____

Allergies:	**List allergy and reaction**
☐None	
☐Allergies to Medication	
☐Latex, Sutures, Tape, Metal, Jewelry,	
☐Other	

Medications with dose and frequency: Include over-the-counter and supplements

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Review of Systems: Do you have any of the following symptoms? Mark all that apply

Cardiovascular
☐Y ☐N Irregular Heartbeat
☐Y ☐N Varicose Veins
☐Y ☐N Chest Pain/Angina

Neurologic
☐Y ☐N Numbness in Any Extremity
☐Y ☐N Weakness in Any Extremity
☐Y ☐N Memory Loss
☐Y ☐N Headaches

General
☐Y ☐N Dizziness/Fainting
☐Y ☐N Weight Gain - unplanned
☐Y ☐N Weight Loss – unplanned

Endocrine
☐Y ☐N Natural Hormone replacement
☐Y ☐N Hot or Cold Flashes/Sweats

Eyes
☐Y ☐N Blurred Vision
☐Y ☐N Blurred Vision

Ears/Nose/Throat
☐Y ☐N Hearing Loss
☐Y ☐N Hay Fever/Sinusitis
☐Y ☐N Teeth or Gum Problems

Skin
☐Y ☐N Bruise easily
☐Y ☐N Rash
☐Y ☐N Itching

Urinary
☐Y ☐N Burning or Painful Urination
☐Y ☐N Trouble Urinating
☐Y ☐N Blood in Urine

Respiratory
☐Y ☐N Shortness of Breath with Walking
☐Y ☐N Coughing
☐Y ☐N Wheezing

Gastrointestinal
☐Y ☐N Constipation
☐Y ☐N Acid Reflux or Heartburn
☐Y ☐N Nausea or Vomiting

Musculoskeletal
☐Y ☐N Chronic joint pain
☐Y ☐N Chronic joint swelling

I _____ **have completed the information above.** **Date:** _____

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Patient History Form

Name: _____DOB:_____Date:_____

Tobacco Use: ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Former ☐ Never Smoker
☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Unknown

Alcohol Use: ☐ Never ☐ Rarely ☐ Social ☐ Daily

Occupation: _____ Physical Requirements of your Work _____
(desk work, long-term standing, lifting more than 20 Pounds, retired)

Sports and Fitness Activities:_____
(walking, running, soccer, football, baseball, softball, volleyball, track, swimming, gymnastics, rugby etc..)

Primary Care Physician: _____

Medical History: Mark all that apply

☐ Bleeding tendencies	☐ Emphysema/COPD	☐ Hiatal hernia	☐ Asthma or wheezing
☐ Blood clots/Phlebitis	☐ Pneumonia	☐ Gallbladder problems	☐ Dizziness/fainting
☐ Pulmonary embolism	☐ Tuberculosis	☐ Gout	☐ Seizures
☐ Stroke	☐ Diabetes	☐ Fibromyalgia	☐ Glasses/Contacts
☐ High blood pressure	☐ Kidney disease	☐ Rheumatoid arthritis	☐ Hearing aids
☐ Heart problems	☐ Urinary infections	☐ Psoriasis	☐ Dentures
☐ Atrial fibrillation	☐ Liver problems/Jaundice	☐ Osteoporosis	☐ Other medical problems:
☐ Reaction to anesthesia	☐ Hepatitis	☐ HIV/AIDS	_____
☐ Sleep apnea	☐ Thyroid problems	☐ MRSA	_____
☐ Arthritis	☐ Stomach ulcers	☐ Cancer (indicate type)	
	☐ Rheumatoid Arthritis	_____	

Surgical History (include fractures, sprains):	Year	Complications
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Family History:

Family Member:	Alive	Deceased	Age	Health status/Cause of death
Father	☐	☐	____	_____
Mother	☐	☐	____	_____
☐ Sister ☐ Brother	☐	☐	____	_____
☐ Sister ☐ Brother	☐	☐	____	_____
☐ Sister ☐ Brother	☐	☐	____	_____
☐ Sister ☐ Brother	☐	☐	____	_____

Please mark any of the following medical problems anyone or your immediate family (mother, father, brother, sister) has had: ☐ Arthritis ☐ Diabetes ☐ Heart Problems ☐ Anesthesia Problems ☐ Blood Clots
☐ Hip fracture ☐ Bleeding Problems ☐ Osteoporosis ☐ Pulmonary Embolism

I _____ have completed the information above. Date: _____

ISMI IDAHO SPORTS™ MEDICINE INSTITUTE

PATIENT:

The information presented here enables you to consent for needed medical services, as well as for the release of information from your medical records for medical and administrative purposes.

CONSENT FOR TREATMENT: I am presenting myself for outpatient care at Idaho Sports Medicine Institute, PA and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by authorized agents and employees of Idaho Sports Medicine Institute, PA and by medical staff or their designees as in their professional judgment may be deemed necessary. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic. *Initial* ____

HIPAA ACKNOWLEDGEMENT: I hereby acknowledge that I have received a copy of the Idaho Sports Medicine Institute, PA Notice of Privacy Practices on this date or on a previous date. *Initial* _____

RELEASE OF INFORMATION: I authorize ISMI to release any information from my medical record, including information about my treatment to a third party payer or a designated review agency for the purpose of processing my claim. *Initial*

PAYMENT AGREEMENT: All services rendered are charged to the patient. We will file your claim if you have supplied us with insurance information in a timely manner. Co-pays, deductible or percentage amounts are due at the time of service unless advance arrangements have been made with ISMI. Monthly statements will be mailed to you and payment is 60 days or older may be transferred to and administrated by Account Billing Services (ABS). ABS will set up a payment plan with you and charge monthly interest. If litigation must be instituted to collect your account then you agree to pay all of the reasonable attorney fees and court costs incurred in collecting the amount due. *Initial* _____

MISSED APPOINTMENTS: Broken appointments or late notice cancellations are a significant cost to the practice. Cancellations are requested 24 hours prior to the appointment to give us the time to offer the time slot to another patient. We reserve the right to charge $50.00 for missed appointments. *Initial* ____

HOSPITAL OWNERSHIP DISCLOSURE: As a patient of Idaho Sports Medicine Institute, your physician may order tests or schedule procedures that are performed at local hospitals. These include (but are not limited to) laboratory tests, x-rays, CT scans, MRIs, injections, and surgical procedures. Some of the physicians at Idaho Sports Medicine Institute are investors at Treasure Valley Hospital, which is one of the local hospitals that provide these services. Our physicians also practice at St Alphonsus and St Luke's where they do not have an ownership interest. This information is to confirm that you understand, as a patient of Idaho Sports Medicine Institute, you have the right to choose the hospital where you would like to receive your services. *Initial* _____

ASSIGNMENT OF BENEFITS (NON-MEDICARE): I hereby authorize payment directly to Idaho Sports Medicine Institute, PA of all healthcare benefits, not to exceed charges, to which I would otherwise be entitled for these services. I agree that the cumulative payments received by ISMI from all sources shall be applied to pay the entire charge for ISMI's medical services without reduction in charges whatsoever for plan adjustments in order that ISMI is paid in full for such services if and when the undersigned has multiple insurance policies or coverages for the medical services being provided by ISMI and the applicable insurance policies or coverages do not coordinate the payment of benefits for such services. I understand that I am responsible for any and all balances owing.

Patient Signature _____ **Date/Time**

ASSIGNMENT OF BENEFITS (MEDICARE ONLY): I request that payment of authorized Medicare benefits be made on my behalf to Idaho Sports Medicine Institute, PA for any services furnished to me by their providers. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it.

Patient Signature _____ **Date/Time**

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND DO VOLUNTARILY AGREE TO ITS PROVISIONS.

Patient _____Date: _____

Responsible _____Relationship_____

(PATIENT MUST BE 18 YEARS OR OLDER TO SIGN. PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE)