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

DATE: _____ Office use only: G L M C S

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

CURRENT SPORT:_____ TEAM/SCHOOL: _____

PATIENT:_____
(LAST NAME) (FIRST NAME) (M.I.) (Preferred name)

PATIENT ADDRESS:_____CITY:_____STATE:____ZIP: _____

DOB:_____AGE:_____ SEX: M F Social Security Number # _____

CELL PHONE:_____WORK PHONE:_____HOME PHONE: _____

PATIENT EMPLOYER: _____

MARITAL STATUS:_____ PATIENT IS A STUDENT: Full –time Part-time

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

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

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

Race: American Indian **OR** Alaskan Native Asian Black/African American White Native Hawaiian **OR** Pacific Islander

Emergency Contact: Name:_____ Relationship:_____ Phone Number:_____

Is the patient the policyholder for insurance? Y N if Yes, Insurance company:_____

Please complete for Patient insurance, Dependent insurance, or other insured.

Spouse Father Mother Other Name:_____

DOB:_____SSN: _____

Employer:_____Cell phone:_____Work phone: _____

Home Address:_____City:_____State:_____Zip: _____
Indicate if same as patient or please complete address line above.

_____
Insurance Company Name Policy ID# Group#

Please complete for Patient insurance, Dependent insurance, or other insured.

Spouse Father Mother Other Name:_____

DOB:_____SSN: _____

Employer:_____Cell phone:_____Work phone: _____

Home Address:_____City:_____State:_____Zip: _____
Indicate if same as patient or please complete address line above.

_____
Insurance Company Name Policy ID# Group#

Please complete for Workers Compensation insurance or Motor Vehicle insurance.

_____

Insurance Company Name and Address Claim Number Phone and Name for Agent or Representative

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*****SIGN HERE:**_____ **DATE:**_____

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

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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 coverage's for the medical services being provided by ISMI and the applicable insurance policies or coverage's 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)*

ISMI IDAHO SPORTS MEDICINE INSTITUTE

Patient's Name:_____ **Date of Birth:**_____ **Height:**_____ **Weight:**_____

Chief complaint/ Reason for visit: R L _____

Is your current problem the result of an injury? No Yes

if Yes, how did it happen? Car Accident Work Accident Other:_____

Date of Injury: _____

How severe is the pain on a scale of 1-10? (circle pain level)**:** None 1 2 3 4 5 6 7 8 9 10 Severe

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

When did it start? __ Hours __ Day(s) __ Week(s) __ Month(s) __ Year(s) **Duration of pain**: _____

PATIENT'S MEDICAL HISTORY: **Primary Care Physician**:_____

	Yes	No		Yes	No		Yes	No
Asthma			Endocrine Disorder			Liver Problems or Jaundice		
Atrial Fibrillation			Fibromyalgia			MRSA		
Bleeding Tendencies			Gallbladder Problems, or Stones, or Disease			Osteoarthritis		
Blood Clots or DVT			Glasses			Osteoporosis		
Concussion			Headaches			Seizure Disorder		
Contacts			Hearing			Sleep Apnea		
COPD			Hepatitis			Stomach Ulcer		
Diabetes Type I			High Blood Pressure			Thyroid Disease		
Diabetes Type II			HIV or AIDS			Other:		
Emphysema			Kidney Disease			☐No Known Medical History		

PATIENT'S SURGICAL HISTORY

	Yes	No	Year	Right, Left, or Bilateral	Surgical Procedure	Yes	No	Year	Right, Left, or Bilateral
Ankle Surgery					Knee – Total Arthroplasty				
Appendectomy					Lumbar Thoracic Surgery				
C-Section					Oophorectomy				
Cataract Surgery					Shoulder - Acromioclavicular Resection				
Cervical Spine Surgery					Shoulder – Acromioplasty				
Cholecystectomy					Shoulder – Labral Repair				
Hernia Repair					Shoulder – Rotator Cuff Repair				
Hip – Labral Repair					Shoulder – Total Arthroplasty				
Hip – Total Arthroplasty					Sinus Surgery				
Hysterectomy					Tonsillectomy				
Knee – ACL Reconstruction					Vasectomy				
Knee – Meniscectomy					Wisdom Teeth				
Knee - High Tibial Osteotomy					Other:				
Knee Tibial Tubercle Transfer					☐No Surgical History				

*****INITIAL HERE:** **DATE:**

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

ISMI IDAHO SPORTS MEDICINE INSTITUTE

PATIENT NAME: _____

PATIENT'S SOCIAL HISTORY

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.)

What is your dominant side: Right Left

Please answer the following questions

	Current every day user	Current some day user	Former User	Never user
Do you smoke				
Do you drink alcohol				
Do you drink caffeine				
Do you use any recreational drugs				

PATIENT'S FAMILY HISTORY

Please indicate any family history by family member.

	Father	Mother	Brother	Sister	Grandmother	Grandfather
Arthritis						
Anesthesia Problems						
Bleeding Problems						
Blood Clots						
Cancer: Breast Colon Lung Lymphoma Ovarian Prostate Uterine Other:						
Diabetes Type I						
Diabetes Type II						
Gout						
Heart Disease						
Hip Fracture						
Osteoporosis						
Pulmonary Embolism						
Other:						
☐ Family History Unknown						
☐ Adopted						

***INITIAL HERE:** **DATE:**

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

PATIENT NAME: _____

IDAHO SPORTS MEDICINE INSTITUTE

PHARMACY name and location: _____

MEDICATIONS you are taking: Name, Strength, How many pills do you take at a time, and How often do you take the pills

Please include over the counter vitamins, supplements etc.

Medication Name	Strength	How many pills do you take at a time	How often do you take the pills
☐ Taking no Medications at this time			

ALLERGIES

	List allergy and reaction
Allergies to Medication	
Latex, Sutures, Tape, Metal, Jewelry	
Other:	
☐No allergies at this time	

REVIEW OF SYSTEMS Do you have any of the following symptoms?

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Cardiovascular			**Endocrine**			**Urinary**		
Irregular Heartbeat			Natural Hormone Replacement			Burning or Painful Urination		
Varicose Veins			Hot or Cold Flashes/Sweats			Trouble Urinating		
Chest Pain/Angina			**Eyes**			Blood in Urine		
Neurologic			Blurred Vision			**Respiratory**		
Numbness in Any Extremity			**Ears/Nose/Throat**			Shortness or Breath with Walking		
Weakness in Any Extremity			Hearing Loss			Coughing		
Memory Loss			Hay Fever/Sinusitis			Wheezing		
Headaches			Teeth or Gum Problems			**Gastrointestinal**		
General			**Skin**			Constipation		
Dizziness or Fainting			Bruise easily			Acid Reflux or Heartburn		
Weight Gain – Unplanned			Rash			Nausea or Vomiting		
Weight Loss - Unplanned			Itching			**Musculoskeletal**		
						Chronic Joint Pain		
						Chronic Joint Swelling		

***SIGN HERE:** _____ **DATE:** _____

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