



DATE: \_\_\_\_\_

Office use only: L M C S Cr

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 No, please complete below policyholder info.

**Please complete for insurance policy holder.**

Relationship to patient: \_\_\_\_\_ 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 secondary insurance policyholder or responsible adult if patient is a minor.**

Relationship to patient: \_\_\_\_\_ 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

\*\*\*SIGN HERE: \_\_\_\_\_ DATE: \_\_\_\_\_

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



**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)*

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **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/Onset of pain:** \_\_\_\_\_

**How severe is the pain on a scale of 1-10?** (Circle One): 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

**Primary Care Physician:** \_\_\_\_\_

**PATIENT'S MEDICAL HISTORY:**

	Past	Current		Past	Current		Past	Current
Asthma			Emphysema			Rheumatoid Arthritis (Joint)		
						Osteoarthritis (Joint)		
Atrial Fibrillation			Fibromyalgia			Osteoporosis		
Bleeding Tendencies			Hepatitis			Seizure Disorder		
Blood Clots or DVT			High Blood Pressure			Sleep Apnea		
Concussion			HIV or AIDS			Stomach Ulcer		
COPD			Kidney Disease			Thyroid Disease		
Diabetes Type I			Liver Problems			Other:		
Diabetes Type II			MRSA			<input type="checkbox"/> No Known Medical History		

**PATIENT'S SURGICAL HISTORY**

Surgical Procedure	Yes	No	Year	Right, Left or Bilateral	Surgical Procedure	Yes	No	Year	Right, Left or Bilateral
Ankle Surgery					Knee-Meniscectomy				
Appendectomy					Knee-Total Replacement				
Back Surgery					Neck Surgery				
C-Section					Shoulder-AC Joint Resection				
Gallbladder Removal					Shoulder-Labral Repair				
Hernia Repair					Shoulder-Rotator Cuff Repair				
Hip-Labral Repair					Shoulder-Total Replacement				
Hip-Total Replacement					Sinus Surgery				
Hysterectomy					Other:				
Knee-ACL Reconstruction					<input type="checkbox"/> No Surgical History				

**\*INITIAL HERE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 (\*PATIENT MUST BE 18 YEARS OR OLDER TO SIGN PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE)

**PATIENT NAME:** \_\_\_\_\_

**PATIENT'S SOCIAL HISTORY**

**Occupation:** \_\_\_\_\_

**Physical Requirements of your work:** \_\_\_\_\_  
(desk work, long-term standing, lifting more than 20 lbs/9 kgs, 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 drink alcohol?				
Do you drink caffeine?				
Do you use recreational drugs?				
Do you smoke, vape or chew? <b>(Circle)</b>				

**PATIENT'S FAMILY HISTORY**

Please indicate any family history by family member.

	Father	Mother	Brother	Sister
Rheumatoid Arthritis				
Anesthesia Problems				
Bleeding Problems				
Blood Clots				
Cancer: Breast Colon Lung Lymphoma Ovarian Prostate Uterine Other:	Type:	Type:	Type:	Type:
Diabetes Type I				
Diabetes Type II				
Gout				
Heart Disease				
Osteoporosis				
Pulmonary Embolism				
Other:				
<input type="checkbox"/> Family History Unknown				
<input type="checkbox"/> Adopted				

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PATIENT NAME: \_\_\_\_\_

PHARMACY NAME AND LOCATION: \_\_\_\_\_

MEDICATIONS you are taking:  
Include over-the-counter vitamins, supplements, etc.

Medication Name	Strength	Route (Mouth, Injection, etc.)	How much do you take at a time?	How often?
<input type="checkbox"/> Taking no medications at this time				

**ALLERGIES**

	List allergy and reaction
Allergies to medication	
Latex, Sutures, Tape, Metal, Jewelry	
Other:	
<input type="checkbox"/> No allergies at this time	

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

	Yes	No		Yes	No		Yes	No
<b>Cardiovascular</b>			<b>Endocrine</b>			<b>Urinary</b>		
Irregular Heartbeat			Natural Hormone Replacement			Burning or Painful Urination		
Varicose Veins			Hot or Cold Flashes/Sweats			Trouble Urinating		
Chest Pain/Angina			<b>Eyes</b>			<b>Respiratory</b>		
<b>Neurologic</b>			Blurred Vision			Shortness of Breath with Walking		
Numbness in any Extremity			<b>Ears/Nose/Throat</b>			Coughing		
Weakness in Any Extremity			Hay Fever/Sinusitis			Wheezing		
Headaches			Teeth or Gum Problems			<b>Gastrointestinal</b>		
<b>General</b>			<b>Skin</b>			Constipation		
Dizziness or Fainting			Bruise Easily			Acid Reflux or Heartburn		
Weight Gain-Unplanned			Rash			Nausea or Vomiting		
Weight Loss-Unplanned			Itching			<b>Musculoskeletal</b>		
<div style="border: 1px solid black; width: 100%; height: 100%; transform: rotate(45deg); transform-origin: center; pointer-events: none;"></div>						Chronic Joint Pain		
						Chronic Joint Swelling		

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