DOUGLAS E. HEMLER, M.D. KYLE C. MORGAN, D.O.

BOARD CERTIFIED PM&R, PAIN MEDICINE, ELECTRODIAGNOSTIC MEDICINE

KIRK W. PROCHNIO, M.S., P.A.-C.

NONSURGICAL ORTHOPEDICS, INTERVENTIONAL SPINE PROCEDURES, SPORTS MEDICINE, ELECTRODIAGNOSIS, OCCUPATIONAL MEDICINE, PAIN MANAGEMENT, REHABILITATION

Please Print

Patient Legal Name (First, MI, Last)	SSN	Date of Birth
☐ Mr. ☐ Mrs. ☐ Ms.	☐ Single ☐ Married ☐ Divorced ☐ Widowed	Email

Address	Home Phone	Work Phone
City, State, Zip Code	Cell Phone	Other Phone

Employer	Occupation	Race	Ethnicity	Language

Collection of race, ethnicity, and language data would allow stratification of quality measures in physician practices to create awareness of differential practice patterns or response among patient populations and accordingly identify opportunities for quality improvement. The ARRA provision for **meaningful use** of EHRs applies to enabling the exchange of health information and reporting on clinical quality measures to CMS, medical boards, private plans, and others.

Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

a. Name________________________ Relationship_______________________ Phone___________________________

b. Name________________________ Relationship_______________________ Phone___________________________

Please list family members or significant others, if any, whom we may inform of your medical condition **ONLY IN AN EMERGENCY**:

c. Name_________________________________ Phone____

d. Name_________________________________ Phone____

Please answer the following question truthfully

Are You on Medicaid? ☐ YES ☐ No

	Primary Insurance	Secondary Insurance
Insurance Name		
Mailing Address for Claims		
Insurance Phone		
Subscriber Name		
Subscriber Relationship to Patient		
Subscriber DOB		
Subscriber SSN (Eligibility Purposes)		
Group ID#		
Policy ID#		

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Name: ______________________________ **Date of Birth:** ____________________

Who referred you to our clinic: ____

Who is your Primary Care Physician: ____

Pharmacy Preference: ______________________ **Phone:** ______________________

Pharmacy Address or location: ____

Height:__________ **Weight:**__________

Purpose for your visit/Injury History: please describe your pain

____
____

Date of Injury	Date pain began	Was the onset of pain: ☐ Gradual ☐ Sudden
Was the injury a result of any of the following?	☐ Vehicle Accident ☐ On the Job	☐ Non Work Related Injury ☐ No known Cause

If a motor vehicle accident, were you wearing a seatbelt?	☐ Yes ☐ No	Comments:
Do you feel that this injury was your employers or another person's fault?	☐ Yes ☐ No	Comments:

Medical Legal

Is there a legal case involved?	☐ Yes ☐ No
Attorney/Claim Adjuster Name	
Attorney/Claim Adjuster Address	
Attorney/Claim Adjuster Phone	
Attorney/Claim Adjuster Fax	
Claim or Case Number	
Med Pay Involved?	☐ Yes ☐ No
Med Pay Capped Ammount	$

Other Treating Providers: You have seen regarding this pain/injury

Physician Name	Specialty	Phone Number	Dates Seen

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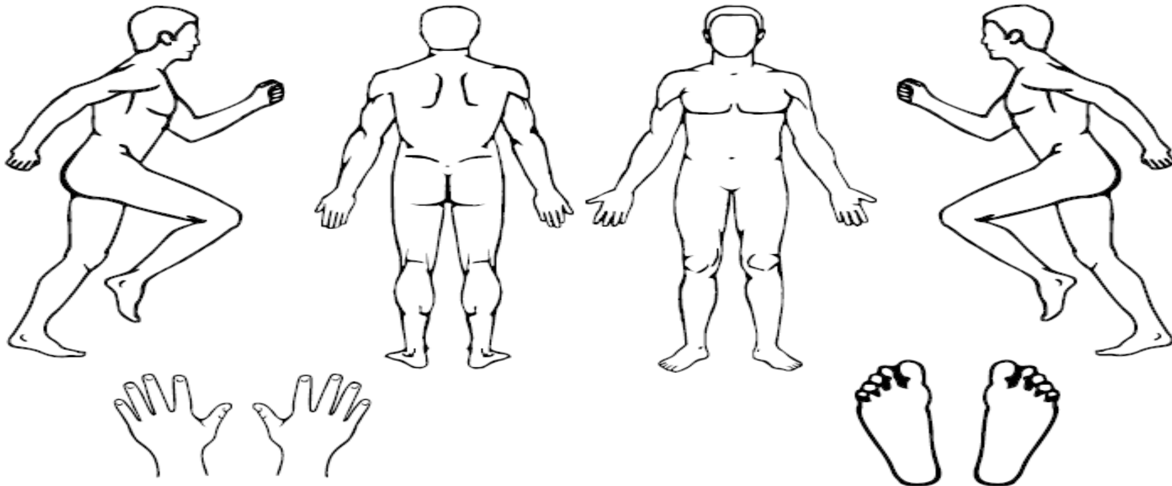
Current Medications: Please list any medications that you take every day, including supplements

Medication Name	Dose	How Often Taken

Allergies

Medication Name	Reaction
Do you have environmental allergies:	☐ Yes ☐ No Please List:
Do you have food allergies:	☐ Yes ☐ No Please List:
Do you have allergies to Latex:	☐ Yes ☐ No
Do you use Marjiuana (THC)?	☐ Yes ☐ No
Do you have a Medical Marijuana Card (Red Card)	☐ Yes ☐ No Who issued it:

Please place an "X" on the lines below indicating the level of your pain over the last two weeks:
A.) What is your pain today? 0 --------------------------------5------------------------------10 (worst pain imaginable)
Please mark the locations of your pain



2801 Youngfield Street, Suite 150 Golden, CO 80401 at the Applewood Tech Center
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Diagnostic Studies

Test	When	Where	Results
☐ X-rays			
☐ CT Scan			
☐ Myelogram			
☐ MRI			
☐ Discography			
☐Bone Scan			
☐EMG			
☐ Other			

Other Treatments

Please check any of the following treatments you have had for this pain/injury:

☐ Physical Therapy	☐ Chiropractic Treatment
☐ TENS unit for home use	☐ Anti-inflamatory Medications
☐ Epidural injections	☐ Narcotic Pain Medications
☐ Facet blocks	☐ Muscle Relaxant Medications
☐ Nerve Root Blocks	☐ Braces/Supports

Past Medical History: Have you ever been diagnosed with any of the following problems?

	Yes	No	Year	Comment
Cancer (Please list type)	☐	☐		
Cardiovascular				
Do you have a pacemaker	☐	☐		
High/Elevated Cholesterol	☐	☐		
High Blood Pressure	☐	☐		
Other Heart Problems	☐	☐		
Respiratory				
Asthma	☐	☐		
COPD	☐	☐		
Tuberculosis	☐	☐		
Gastrointestinal				
Hepatitis	☐	☐		
Reflux	☐	☐		
Ulcers	☐	☐		
Kidney				
Renal Failure	☐	☐		
Mental and Emotional				
Depression (being treated)	☐	☐		
Anxiety (requiring treatment)	☐	☐		
Hematologic/Immunity				
Anemia	☐	☐		
HIV/AIDs	☐	☐		
Mononucleosis	☐	☐		
Bleeding after surgery	☐	☐		
Blood Transfusion	☐	☐		
Other not listed				

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Past Hospitalizations and Surgeries

Date/Year	Reason for Admission	Physician	Hospital

Review of Systems: Do you **currently** have any of the following problems

	Yes	No	Comment
General Health Problems			
Fever	☐	☐	
Chills	☐	☐	
Night Sweats	☐	☐	
Weight Loss/Gain (>10 lbs/month)	☐	☐	
Head/Neck			
New Headache	☐	☐	
Vision/Eye Problems	☐	☐	
Earache, Loss of Hearing	☐	☐	
Chronic Sinus Infections	☐	☐	
Cardiovascular			
Blacking out/Fainting	☐	☐	
Bluish Discoloration of Lips/Fingernails	☐	☐	
Chest Pain	☐	☐	
Irregular Heartbeat/Palpitations	☐	☐	
Swelling of Ankles	☐	☐	
Respiratory			
Frequent non-productive cough	☐	☐	
Frequent productive cough	☐	☐	
Shortness of breath	☐	☐	
Short of breath climbing 1 flight of stairs	☐	☐	
Wheezing	☐	☐	
Gastrointestinal			
Difficulty swallowing	☐	☐	
Abdominal pain	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Heartburn	☐	☐	
Nausea	☐	☐	
Vomiting	☐	☐	
Blood in stools	☐	☐	
Black, tar-like stools	☐	☐	

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Neurologic		
Numbness	☐ ☐	
Tingling	☐ ☐	
Seizures	☐ ☐	
Weakness	☐ ☐	
Urologic		
Blood in urine	☐ ☐	
Difficulty Starting Urination	☐ ☐	
Burning	☐ ☐	
Leaking of Urine	☐ ☐	
Mental and Emotional		
Depression (requiring treatment)	☐ ☐	
Anxiety (requiring treatment)	☐ ☐	
Endocrine		
Feel cold all the time	☐ ☐	
Feel hot when others do not	☐ ☐	
Increased Appetite	☐ ☐	
Diabetes	☐ ☐	
Thyroid Deficiency	☐ ☐	
Thyroid Excess	☐ ☐	
Hematologic		
Swollen Lymph Nodes	☐ ☐	
Bruising Easily	☐ ☐	
Bleeding into joints	☐ ☐	
Skin Problems		
Itching	☐ ☐	
Rash	☐ ☐	

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Assignment of Benefits

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. If my account is referred to collection, I agree to pay reasonable collection expenses including attorney's fees. In the event that I am entitled to health insurance or other benefits relating to my medical condition and available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. I understand that there will be a $50 charge for cancelling an office appointment with less than 24 hours notice or failing to attend an appointment with no notice. I also understand there is a $150 cancellation fee for cancelling a surgery center appointment with less than 48 hours notice. Further, I understand that there will be a charge for telephone consultations. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I further permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

HIPAA - Notice of Privacy Notices

I acknowledge that I will be given a copy of the Notice of Privacy Practices for Douglas Hemler M.D. and Kyle Morgan, D.O., and Kirk Prochnio, P.A.-C if I request a copy.

FMLA/Disability Form Completion

I am aware that an appointment is required for all forms to be completed. This includes but is not limited to FMLA and Disability Paperwork. There is also a two week turn-around time for all forms so please plan ahead.

Check in time / arrival time policy

Our office requires that all new patients arrive forty minutes early, all established patients arrive fifteen minutes early for appointments, patients having a procedure in the office arrive thirty minutes early. We ask our patients to arrive prior to their scheduled appointment time because we do have multiple patients scheduled with multiple providers. This early arrival time allows our staff adequate time to process all the necessary paperwork in a timely fashion in order to help keep all of our providers on schedule, and to honor your scheduled appointment. In the event that our providers are running late, we will make every attempt to notify you prior to your arrival. If you are not able to arrive early as our policy states, you may be asked to reschedule. A late notice cancel fee may apply. If you are a self pay new patient we require payment seven days in advance. You need to pay all co pays at check in before being seen by a provider, we cannot bill this out, if you cannot pay your co pay we will need to reschedule.

I understand that if my insurance requires a referral/authorization for my visit, I am responsible for making sure that the referral is obtained from my primary care physician for each date services are rendered. I also understand that if the referral from the primary care physician's office is not received before/on the day of each and every one of my appointments, I agree to pay for all services rendered on the day of the visit.

I voluntarily give consent for my medical treatment or my child's medical treatment to the providers at Sports and Orthopedic Rehabilitation, PLLC, d/b/a STAR Spine and Sport. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.