SAWTOOTH ORTHOPEDICS & SPORTS MEDICINE
Patient Information Sheet

Today's Date: ______________________ Primary Physician: ______________________

PATIENT
Name: ______________________ DOB: ______________ Age: ______

SSN: ______________________ Marital Status: ______________ Male / Female

Physical Address: ____

Mailing Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Email address: ____

Preferred Method of Contact? (circle one) Home Phone / Cell Phone / Email / Postal

Employer: ______________________ Occupation: ______________________

I have provided a current copy of my insurance card: YES / NO

GUARANTOR / PRIMARY NAME ON INSURANCE (if differs from above)
Name: ______________________ DOB: ______________ Age: ______

SSN: ______________________ Marital Status: ______________ Male / Female

Physical Address: ____

Mailing Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Email address: ____

Preferred Method of Contact? (circle one) Home Phone / Cell Phone / Email / Postal

Employer: ______________________ Occupation: ______________________

EMERGENCY CONTACT
Name: ______________________ Phone: ______________ Relation:__________

Name: ______________________ Phone: ______________ Relation:__________

MEDICAL INFORMATION
Chief Complaint (right or left): ______________________________________

Was this an injury? YES / NO Date of injury: ______________________

Briefly describe **how** and **where** the injury occurred: ______________________

____

Date of first treatment: ______________ Doctor who treated/referred you: ______________

WORKER'S COMPENSATION INFORMATION

Was injury caused or aggravated by your job? YES / NO Have you filed a work comp claim? YES / NO

Work Comp Insurance Carrier: ______________________ Claim No.______________

SAWTOOTH ORTHOPEDICS & SPORTS MEDICINE

Outpatient Services Consent

I understand that I am financially responsible for the payment of medical charged incurred on my behalf at Sawtooth Orthopedics and Sports Medicine, regardless of third party coverage. I authorize my insurance company or any responsible third party to pay benefits to Sawtooth Orthopedics and Sports Medicine. I consent to a photograph to go into my electronic medical record for identification purposes.

SIGNATURE: ____ DATE: __________________

I voluntarily consent to care by St. Luke's, its employees and contractors, as well as members of the medical staff who are independent practitioners and note employees are contractors of St. Luke's. Such care includes, but is not limited to, routine x-rays, laboratory and other diagnostic procedures, medical treatment and other medical services as necessary in the treating physician's (or designee's) judgment and normally provided by St. Luke's/ Sawtooth Orthopedics and Sports Medicine. This may include the taking of photographs and video that may be useful in treating or diagnosing my conditioning or that may be useful for medical education purposes or for making a photographic record for my condition.

I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatments or examinations. As a patient of St. Luke's/Sawtooth Orthopedics, I understand that individuals being trained in health care may participate in my care. I also understand that health care vendors may be present during my care. I consent to their presence and assistance under general supervision according to St. Luke's policy.

PERSONAL PROPERTY: I understand St. Luke's/Sawtooth Orthopedics is not responsible for loss or damage to my personal property brought to St. Luke's/Sawtooth Orthopedics.

FINANCIAL CONSENT: I agree to be responsible for payment of all St. Luke's/Sawtooth Orthopedics charges. I also agree to be responsible for all professional fees covered by insurance or not. I will submit applications to federal, state and my county programs when appropriate. I understand St. Luke's and its independent practitioners will bill me, my family and/or other responsible parties for services provided.

ASSIGNMENT OF INSURANCE PAYMENT: I voluntarily assign St. Luke's and its independent practitioners the right to pursue their respective claims for reimbursement. I understand claims may be made upon any health insurance policy or policies providing coverage for care and treatment for physician services rendered.

PATIENTS RIGHTS AND RESPONSIBILITIES: My signature confirms that I have been provided/offered the St. Luke's/Sawtooth Orthopedics Patient Rights Brochure.

Patient's Signature: ____________________________________ Date&Time: ____________________

The patient is unable to sign because: ____

Signature: ____ Date&Time: ____________________

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have been offered a copy of St. Luke's/Sawtooth Orthopedics Notice of Privacy Practices on this day or on a previous visit to Sawtooth Orthopedics and Sports Medicine.

Patient's Signature: ____________________________________ Date&Time: ____________________