CODY REGIONAL HEALTH

ORTHOPEDIC CLINIC

720 Lindsay Lane Suite C., Cody, WY 82414

Date: _____

Patient Name:

_____

Last Name **First Name** **Middle Initial**

DOB: _____ **GENDER:** Male Female **Marital Status:** _____

SS#: _____ **Height:** _____ **Weight:** _____

Phone Home: _____ **Cell:** _____ **Work:** _____

Consent to call? YES NO **Consent to Text?** YES NO

Email address: _____ **Web Portal Access:** Yes No

Address:

_____

_____

Guarantor (if patient a minor)**:**

_____ **DOB:** _____

Emergency contact information:

Name: _____

Relationship: _____ **Phone Number:** _____

Insurance:

_____

ID#: _____ **Subscriber:** _____ **DOB:** _____

Language: _____ **Race:** _____ **Ethnicity:** _____

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Name: _____ **DOB:** _____

Primary Care Provider: _____ **Referring Provider:** _____

Pharmacy: _____ **Location:** _____

Current Medication:
Please include vitamin/Supplements Dose or Strength How often

Allergies:
Medication and/or intolerances,
latex allergy, metals and reaction No known allergy's

Family History: Has anyone in your immediate family had any of the following conditions? If family member unknown please list unknown.

(If adopted or unknown circle) **Adopted Unknown**

Condition	**Family Member**	**Condition**	**Family member**
Anemia		Heart Disease	
Aneurysm		High Cholesterol	
Arthritis		Kidney Disease	

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Asthma		Myocardial Infarction	
Cancer-list type		Osteoporosis	
COPD		Osteoarthritis	
Clotting disorder		Rheumatoid arthritis	
Diabetes		Seizures	
Emphysema		Stroke	
High Blood Pressure		Other	

Social History:

• Tobacco use: ☐ Never ☐ Former ☐ Current every day Packs Per Day for years ☐ Chew, snuff

• Alcohol use: ☐ Never ☐ Occasionally ☐ Daily Type

• Street drug use: ☐ Never ☐ Occasionally ☐ Daily Type

• What is your Occupation? _____

• Do you live with anyone who can take care of you at home? ☐ Yes ☐ No

Surgeries: Please list surgery's and name of surgeon. Especially all spine, arm and leg: Be specific.

Surgeries	**Name of Surgeon**

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

☐ A-Fib
☐ Anemia
☐ Anxiety/Depression
☐ Arthritis
☐ Asthma
☐ Autism
☐ Bleeding Disorder
☐ Blood Clots
☐ Cancer type:
☐ Cardiac Stent
☐ Chronic Pain
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Diabetes
☐ Fracture HX
☐ GERD
☐ Gout
☐ Heart Attack (MI)
☐ Heart Disease
☐ Hepatitis
☐ High Cholesterol
☐ Hypertension
☐ Kidney Disease
☐ MRSAdate:
☐ Osteoporosis
☐ Pacemaker
☐ Pulmonary Embolism
☐ Rheumatoid
☐ Seizures / Epilepsy
☐ Sleep Apnea
Machine D Y D N
☐ Stroke
☐ Thyroid Problems
☐ PTSD
☐ Other:

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PATIENT DISCLOSURE RECORD

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone: _____

☐ Okay to leave message with details ☐ Okay to leave message with callback number only

☐ Work Number: _____

Written Communication: _____

☐ Okay to mail to my home address ☐ Okay to mail to my work/office address.

☐ Okay to FAX to this number: _____

Work Number:

☐ Okay to leave message with details ☐ Written Communication:

☐ Okay to mail to my home address ☐ Okay to mail to my work/office address.

☐ Okay to FAX to this number:_____

☐ Other: ☐ Okay to leave message with callback number

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do ncit apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO (treatment, payment and healthcare operations) may be permitted without prior consent in an emergency.

People with whom we can speak to about your care and treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____