



STEADMAN CLINIC
Keeping People Active

STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION

Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ Male Female

Home phone _____ Work _____ Fax _____

Cell Phone _____ e-mail Address _____

Permanent Mailing Address _____

City _____ State _____ Zip _____

Local Address _____ Phone _____

City _____ State _____ Zip _____

Patient's Employer _____ Address _____

City _____ State _____ Zip _____

Occupation _____ Retired? Y N

Marital Status S M W D Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Relative to contact in case of an emergency _____
(A relative not living with you)

Relationship _____ Phone _____

Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How were you referred to us? _____

Injury Information:

Date of injury _____ Work related: No Yes Auto Accident: No Yes

What is injured _____

Describe injury _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Carrier _____
Address _____ City _____
State _____ Zip code _____ Phone _____
Policy ID Number _____ Group _____
Name of the Policy Holder _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Social Security number _____ Sex M F
Employer _____ Occupation _____

SECONDARY INSURANCE COMPANY:

Carrier _____
Address _____ City _____
State _____ Zip code _____ Phone _____
Policy ID Number _____ Group _____
Name of the Policy Holder _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Social Security # _____ Sex M F
Employer _____ Occupation _____

WORKMAN'S COMPENSATION INSURANCE:

Carrier _____
Address _____ City _____
State _____ Zip code _____ Phone _____
Claim Number _____ Case Worker's Name _____
Case Worker's Phone Number _____ Fax _____
Employer at time of injury _____
Address _____

ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient _____ Date _____
Responsible Party _____ Date _____

Steadman Clinic, Professional LLC

STATEMENT OF FINANCIAL LIABILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges at the time of the visit. I understand that unless otherwise indicated below, I hereby request and authorize Steadman Clinic to bill insurance policies written in the United States, and insurance companies based in the United States, for surgical and other charges for services provided to me, and I authorize payment to the Steadman Clinic for all such services. I further understand and agree that I will be required to provide a down payment prior to receiving the services based on my estimated financial responsibility. I also understand that Steadman Clinic physicians are investors in the Vail Valley Surgery Center.

NOTICE OF LIABILITY FOR “NON-COVERED” SERVICES

I understand that my insurance carrier or Medicare may deny payment or consider some or all services performed by Steadman Clinic, such as assistant surgeons, and supplies, to be “non-covered,” and I am fully responsible for payment of all such non-covered services.

WAIVER OF “USUAL, CUSTOMARY AND REASONABLE” CLAUSES

For patients with “UCR” coverage I acknowledge that the fees charged by Steadman Clinic for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered “usual, customary and reasonable,” due to specialized services and staff. However, I agree to pay all fees in full, even if the amount is greater than the amount paid by my insurance company.

CHANGES TO BILL TO/PAYMENT INSTRUCTIONS

By checking the box to the left, I hereby direct that Steadman Clinic SHALL NOT bill my insurance company for services provided to me, and instead I agree to pay all fees for services furnished to me by Steadman Clinic.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize Steadman Clinic to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-party payers or their reviewing agencies, as reasonably necessary to expedite claim processing. This authorization is valid for every visit to Steadman Clinic or its affiliates until written notice revoking it is provided. I release Steadman Clinic of all responsibility or liability for loss of confidentially through access and/or copies of records released, or other information disclosed in compliance with this authorization.

I have read all of the above and understand/agree to all provisions there in regarding responsibility for payments and release of information.

Patient’s Name: _____

Patient or Legal Guardian’s Signature: _____ Date: _____

If Legal Guardian, Relationship to Patient: _____



PATIENT HISTORY

Please PRINT and fill out completely.

Name: _____ Nickname: _____ Today's Date: _____

Age: _____ Height: _____ Weight: _____ What body part is injured: _____ Right Left
Hand Dominance: Right Left

HISTORY OF INJURY

Is the injury **CHRONIC**? Yes No If **YES**, how long has it been going on for? _____

Is the injury **NEW** as a result of a specific injury? Yes No If **YES**, date of injury/accident: (full date) ____/____/____

Describe in your own words how the initial injury occurred and how it limits your current level of activity:

Did your problems begin following: Work injury? Motor Vehicle Accident? **What State?** _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful): At rest: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: Worsening Stable Improving Constant Occasional Sharp Dull
 Aching Stabbing Throbbing

What symptoms are you experiencing? Locking Catching Giving Way Popping Grinding Bruising
 Numbness Tingling Other (describe) _____

What, if anything, makes your symptoms *better*? Rest Activity Cold Therapy Heat Therapy
 Medication Other _____

What, if anything, makes your symptoms *worse*? Inactivity Exercise (describe) _____
 Other _____

Have you seen another physician for this injury? Yes No
If yes, who? _____

What treatments have you tried? Nothing Physical Therapy Exercise Acupuncture
 Chiropractic Bracing Injections (i.e: Synvisc, Hyalgan) Ice Decreased activity
 Medications _____ Other _____

Have you had any of the following tests/studies?

Test	Date (month / year)	What facility? (clinic / hospital)
<input type="checkbox"/> X-rays	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

Recreational Activities: _____

Current, regular exercise program (if any): _____

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

<input type="checkbox"/> High blood pressure	_____	<i>When?</i>	_____	<input type="checkbox"/> Osteoporosis	_____	<i>When?</i>	_____
<input type="checkbox"/> Deep vein thrombosis	_____			<input type="checkbox"/> Kidney Disease/Problem	_____		
<input type="checkbox"/> Liver Disease	_____			<input type="checkbox"/> Seizures	_____		
<input type="checkbox"/> Heart Disease or Attack	_____			<input type="checkbox"/> Arthritis	_____		
<input type="checkbox"/> Stroke	_____			<input type="checkbox"/> Thyroid <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo	_____		
<input type="checkbox"/> Cancer (<i>where?</i>)	_____			<input type="checkbox"/> Tuberculosis	_____		
<input type="checkbox"/> Elevated cholesterol	_____			<input type="checkbox"/> Pulmonary embolism	_____		
<input type="checkbox"/> Ulcer Disease	_____			<input type="checkbox"/> Polio	_____		
<input type="checkbox"/> Gastritis	_____			<input type="checkbox"/> Rheumatic Fever	_____		
<input type="checkbox"/> Reflux Disease (GERD)	_____			<input type="checkbox"/> Gout	_____		
<input type="checkbox"/> Asthma	_____			<input type="checkbox"/> Depression	_____		
				<input type="checkbox"/> Diabetes	_____		

Others, please list: _____

Have you ever had a blood transfusion? Yes No If yes, when? _____

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? Yes No If yes, when? _____

Do you have a history of GI, stomach bleed? Yes No If yes, when? _____

Do you take any medications for your stomach? (*Please include over the counter medications; i.e. Pepcid, Tums, Zantac, etc., dosage and frequency.*) _____

PAST SURGICAL HISTORY

Please list all surgeries you have had in the past:

<i>Type of Surgery</i>	<i>Date</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any problems with Anesthesia? Yes No Please explain if **YES**: _____

ALLERGIES

Are you allergic to any medication? Yes No **known drug allergies**

If **YES**, please list all medications that you are allergic to and the associated reaction (i.e. Penicillin (hives) etc): _____

Are you allergic to: Sulfa? Yes No Latex? Yes No Steroids? Yes No

Please list all food allergies (i.e. eggs, shellfish): _____

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include Vitamin, Mineral and Herb supplements.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Marital Status: Married Single Divorced Widowed Living with other Living alone

Occupation: _____

Tobacco Use: Yes No Type: _____ Duration: _____ Quit Date: _____

Alcohol Use: Yes No Frequency: _____

Caffeine Use: Yes No Frequency: _____

Recreational Drug Use: Yes No Frequency: _____

FAMILY HISTORY

Please check family history conditions:

Blood Clots Diabetes Hypertension Rheumatoid Arthritis Anesthetic problems
 Cancer Heart Disease Osteoporosis Stroke Seizures

Please describe any immediate family history medical problems: _____

REVIEW OF SYSTEMS

1. CONSTITUTIONAL GENERAL None Weight gain Weight loss Chills Fever Weakness/Fatigue
 Other _____

2. EYES None Blurred vision Glasses Contacts Eye pain Redness
 Other _____

3. EARS, NOSE, THROAT None Nose bleeds Ear ache or infection Ringing in ear Hoarseness
 Other _____

4. CARDIOVASCULAR None Chest Pain Swelling in legs Shortness in breath Palpitations
 Other _____

5. RESPIRATORY None Shortness of breath Wheezing/Asthma Frequent Cough
 Other _____

6. GASTROINTESTINAL None Heartburn Vomiting Nausea Abdominal Pain
 Other _____

7. MUSCULOSKELETAL None Stiffness Muscle aches Swelling of joints Instability
 Other _____

8. SKIN None Rash Itching Redness Keloid scars Psoriasis
 Other _____

9. NEUROLOGICAL None Headaches Numbness, tingling, loss of sensation in any part of body
 Dizziness Poor balance Fainting spells Seizures
 Other _____

10. PSYCHIATRIC None Depression Nervousness Anxiety
 Other _____

11. ENDOCRINE None Excessive thirst or hunger Hot/cold intolerance Hot Flashes
 Other _____

12. HEMATOLOGICAL None Easy Bruising Easy Bleeding Varicose veins Blood clots
 Other _____

Signature: _____ Date: _____

Print name: _____

Accommodations/Transportation

In preparing for your stay in Vail, the following are phone numbers for some local hotels and condominiums in the Vail/Beaver Creek area that offer discounts to our patients.

Comfort Inn (Avon, CO)	800-545-8422	970-949-5511	www.comfortinn.com
Evergreen Lodge at Vail	800-284-8245	970-476-7810	www.evergreenvail.com
Holiday Inn Apex Vail	866-317-2739	970-476-2739	www.apexvail.com
Lion Square Lodge	800-525-1943	970-476-2281	www.lionsquare.com
Mountain Haus	800-237-0922	970-476-2434	www.mountainhaus.com
Simba Run Condominiums	800-746-2278	970-476-0344	www.simbarun.com
Sonnenalp Resort of Vail	866-284-4411	970-476-5656	www.sonnenalp.com
The Sitzmark Lodge	888-476-5001	970-476-5001	www.sitzmarklodge.com
The Lodge at Vail	877-528-7625	970-476-5011	www.lodgeatvail.com
Vail Cascade Resort	800-282-4183	970-476-7111	www.vailcascade.com
Vail Plaza Hotel	866-597-5963	970-477-8000	www.vailplazahotel.com

Airport Shuttle Services:

Colorado Mountain Express (CME)	800-525-6363	970-926-9800	www.ridecme.com
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Rental Cars:

Alamo- Eagle Airport	800-462-5266	970-524-2277	www.alamo.com
Avis – Eagle Airport	800-331-1212	970-524-7571	www.avis.com
Budget – Eagle Airport	800-527-0700	970-524-8260	www.budget.com
Dollar- Eagle Airport	800-800-4000	970-524-9429	www.dollar.com
Hertz- Eagle Airport	800-654-3131	970-524-7177	www.hertz.com
National – Eagle Airport	800-227-7368	970-524-2277	www.nationalcar.com

Taxis, Limousines:

Black Diamond	970-261-6509		www.blackdiamondcars.com
Eco Limo of Vail	970-331-3135		www.ecolimoofvail.com
Hummers of Vail	970-977-0028		www.hummersofvail.com
Powderhound Transport	970-455-4315		www.ridethepowder.com
RJ Limo of Vail	800-887-9643		www.limovail.com
Vail Coach	877-554-7433	970-477-0001	www.vailcoach.com
Vail Local Limo	970-343-0500		www.vaillocallimo.com
Vail Valley Taxi	970-476-8294		

Buses:

Town of Vail Bus Schedules	970-479-2178		www.vailgov.com
Eagle County Bus Schedules	970-328-3520		www.eaglecounty.us

Directions

Steadman-Hawkins Clinic
181 West Meadow Drive, Suite 400
Vail, Colorado 81657
970-476-1100

FROM DENVER (EAST) TO VAIL (WEST)

Exit the Denver International Airport and take Pena Boulevard to Interstate 70 heading west. Go approximately one hundred and twenty miles (120) to Vail, Exit 176. Follow the roundabout half way around and exit in the direction of Vail Village. Enter the second roundabout and exit in the direction of Vail Road. Go to the stop sign and turn right onto West Meadow Drive. Go ¼ mile and turn right at the Vail Valley Medical Center. Enter through the main entrance and take the main elevators to the third floor. The Steadman-Hawkins Clinic is located on the third floor of the hospital.

FROM EAGLE (WEST) TO VAIL (EAST)

Exit Eagle County Airport and turn left (east) on Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Exit the roundabout in the direction of Vail road. Go to the stop sign and turn right on West Meadow Drive. Go ¼ mile and turn right at the Vail Valley Medical Center. Enter through the main entrance and take the main elevators to the third floor. The Steadman Hawkins Clinic is located on the third floor of the hospital.

