THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ Sex ☐ M ☐ F

Race _____ Ethnicity _____ Language _____

Cell Phone _____ Work Phone _____ Home Phone _____

Fax _____ E-mail Address _____

Permanent Mailing Address _____

City _____ State _____ Zip _____

Occupation _____ Retired? ☐ Y ☐ N

Marital Status ⋯_____ Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Relative to Contact in Case of 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 _____ 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 _____ 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 _____

WORKMAN'S COMPENSATION INSURANCE:

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Claim Number _____ Case Worker's Name _____

Case Worker's Phone Number _____ Fax _____

Employer at Time of Injury _____

Address _____

Patient _____ Date _____

Responsible Party _____ Date _____

UNACCOMPANIED MINOR WAIVER

This section is required to be signed by a parent or legal guardian in order for an unaccompanied minor to be seen by any physician or clinical staff at The Steadman Clinic. By signing, you (parent/guardian) agree that The Steadman Clinic may evaluate and treat the unaccompanied minor in whatever way is medically necessary.

Parent/Guardian Signature: _____ ***Date:*** _____

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.

THE STEADMAN CLINIC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Location: 181 West Meadow Drive, Ste 400, Vail, Colorado 81657 | T 970.476.1100 | F 970.479.5835
Email: medicalrecords@thesteadmanclinic.com | **Hours of Operation:** 8 a.m. - 5 p.m. Monday - Friday

Patient Information:

Patient Name: _____ Date of Birth: _____

Phone: (_____) _____ Alias: _____ Email: _____

I direct and hereby authorize The Steadman Clinic to deliver or communicate the Protected Health Information specified in this authorization to myself and the party or parties specified in the following medium:

☐ Landline ☐ Message on Voicemail ☐ Cell Phone ☐ Message on Voicemail ☐ Text Message ☐ E-mail ☐ Fax ☐ Mail

I request my protected health information (PHI) to be used or disclosed to the following person, class of persons, or organization:

☐release of medical records ☐ verbal discussion ☐ no records sent at this time please keep

Name: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____

I request my protected health information (PHI) to be released from my medical record(s): (Please check all that apply or describe the information specifically).

☐ Discharge Summary ☐ Discharge Instructions ☐ History and Physical ☐ ER Record ☐ Medication Records ☐ Lab Report ☐ Treatment Plan ☐ Clinic Note ☐ Consultation ☐ Operative Report ☐ Pre-Operative ☐ Notes EKG / ECG

☐ Provider's Name: _____
☐ Other: _____
☐ Specific Date(s): _____ to _____ **or if no dates are specified, the last two (2) years will be released.**

I authorize the release of information in my health record which may include information related to:

☐ Behavioral or Mental Health Issues ☐ Sexually Transmitted Diseases ☐ Sexual Assault Nurse Examiner Reports
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus
☐ (HIV) Alcohol and Drug Treatment

Purpose for requesting information: (Please check one)

☐ Request of Patient ☐ Continuation of Care ☐ Other: _____

By signing this authorization, I understand that:

- The authorization form is in effect until revoked by me, or until any records retention period applicable to my records has expired, whichever is sooner.
- Electronic media and delivery methods such as e-mail, or text messages, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of TSC/SPRI. I agree to assume such risks personally, and to hold TSC/SPRI harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing TSC/SPRI to transmit or deliver such information electronically.
- My refusal to sign this form will not adversely affect my ability to receive health services, reimbursement for services and an enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature. I acknowledge the information disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer protected by Federal Law.
- I have the right to revoke this authorization by written notice to TSC/SPRI. I understand actions taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.
- There may be costs associated with this request in compliance with State copying laws.

Patient/Authorized Representative* Signature:_____ Date:_____

Printed Name of Authorized Representative:_____ Relationship to Patient:_____

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

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Dr. Donald S. Corenman, MD
New Patient Spine History

Date: _____

Name: _____ **Age:** _____**yrs.** **DOB:**_____

Height: ____ft ____in **Weight**: ____lbs **Sex:** ☐ Male ☐ Female **Are you or could you be pregnant?** ☐ Yes ☐ No

HISTORY OF CURRENT SPINAL PROBLEMS

Date of current spinal injury or problem: _____

List your chief complaints or main problems with the most severe first:

1._____

2._____

3._____

Describe all details of any accident, incident or the way these problems began:

_____

_____

_____

CURRENT SYMPTOMS

What time of the day is your pain at its worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Not Applicable

Does the pain wake you up at night? ☐ Yes ☐ No

In the past six months have you experienced: ☐ Fever ☐ Weight Loss_____lbs ☐ Chills ☐ Night Sweats

How would you describe your pain? ☐ Constant ☐ Constant, but worse with activity ☐ Intermittent (comes and goes) ☐ Intermittent, but worse with activity

Do you have full control of your bladder? ☐ Yes ☐ No

Do you have full control of your bowels? ☐ Yes ☐ No

What treatments have you tried for this condition?

☐ Nothing ☐ Decreased Activity ☐ Physical Therapy - If so, when did you start?_____

☐ Exercise ☐ Acupuncture ☐ Chiropractor ☐ Bracing ☐ Ice ☐ Injections

☐ What medications have you tried for this condition? (OTC, Rx) : _____

☐ Other:_____

HISTORY OF CARE

Who is your primary care physician?_____ **Clinic / Facility:** _____

Address:_____ **Phone:** _____

Please list any other doctors, clinics, or hospitals you have seen for your <u>current spinal problems</u>:

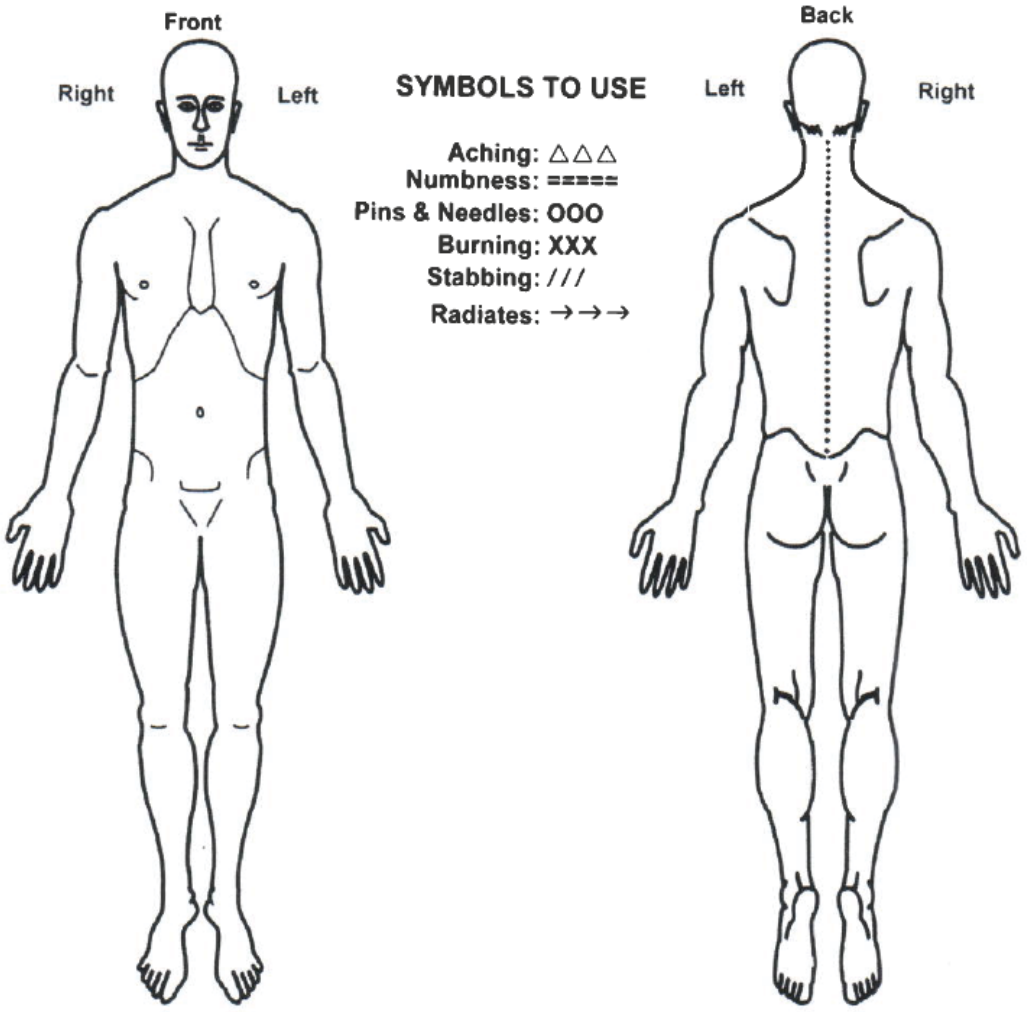
Name	City	Date of Visit
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all <u>spine</u> surgeries/ procedures you have had in the past:

Type of Surgery or Procedure	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates including all affected areas.



For each area of your body, please mark where your symptoms (pain, numbness, weakness, etc.) exist on "average" and at the "worst." ZERO is no symptoms - > TEN is the worst pain of your life

Current **Neck** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **Low Back** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Current **Shoulder** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **SI** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Current **Arm** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **Buttock** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Current **Mid Back** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **Groin** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
	Current **Leg** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

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WORK HISTORY

Are you currently: ☐ Employed ☐ Unemployed ☐ Retired ☐ Sick Leave ☐ Disability

Has your job changed since your symptoms started? ☐ Yes ☐ No ☐ Not Working

If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? ☐ Yes ☐ No

If you are working, are you on: ☐ Normal Duties ☐ Light Duties

Did your current symptoms cause you to go on light duty at work? ☐ Yes ☐ No

Are you applying for disability? ☐ Yes ☐ No

Please describe your job:_____

WORKMAN'S COMPENSATION HISTORY

Is this a workers compensation case? ☐ Yes ☐ No

Have you had any PRIOR workers compensation injuries? ☐ Yes ☐ No **If yes, how many?** _____

Please list any prior workers compensation cases/injuries:

Date	*Area Injured*	*Time Off Work*	*Who Treated You?*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were you at work when your symptoms began? ☐ Yes ☐ No

Did you have a specific accident or injury while at work to cause your symptoms? ☐ Yes ☐ No

What is the company name? _____

Prior to your WC injury, how long had you been employed by that company? _____

Do you currently have an attorney for this episode? ☐ Yes ☐ No

CAR ACCIDENTS

Were your symptoms caused by a car accident? ☐ Yes ☐ No

Have you had any PRIOR car accidents? ☐ Yes ☐ No **If yes, how many?** _____

Please List:

Date	*Area Injured*	*Time Off Work*	*Who Treated You?*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you currently have an attorney for this episode? ☐ Yes ☐ No

Directions – The Steadman Clinic Vail Location
181 West Meadow Drive, Suite 400
Vail, CO 81657
Phone: (970) 476-1100

From Denver (East) to Vail (West)

Exit the Denver International Airport and take Pena Boulevard to Interstate 70 heading West. Follow Interstate 70 West approximately 120 miles to Vail, Exit 176. Follow the roundabout half-way around and exit in the direction of Vail Village (under the Interstate). Enter the second roundabout and exit at the South Frontage Road West. Parking is located approximately 150 yards down the road and to the left at the Vail Valley Medical Center in the parking structure located directly after the US Bank building. Parking attendants will help give directions on parking or can valet cars upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.

From Eagle (West) to Vail (East)

Exit the Eagle County Airport onto Cooley Mesa Road going East. At the stop light turn right (East) on Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Enter the roundabout and exit at the South Frontage Road West. Parking is located approximately 150 yards down the road and to the left at the Vail Valley Medical Center in the parking structure located directly after the US Bank building. Parking attendants will help give directions on parking or can valet cars upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.