THE STEADMAN CLINIC AND STEADMAN PHILIPPON RESEARCH INSTITUTE

U.S. OLYMPIC NATIONAL MEDICAL CENTER


**Robert F. LaPrade, M.D. PhD**
Complex Knee & Sports Medicine

**Amanda Peña**
Practice Coordinator

**Nick DePhillipo**
Athletic Trainer & Surgical Assistant

**Fred Cook**
Physician Assistant

**Chris Armstrong**
Physician Assistant


Thank you for choosing The Steadman Clinic!

Please complete all registration forms, patient portal, and research forms prior to the date of your scheduled office visit. Completing paperwork will expedite your registration process the day of the visit.

If you are unable to complete the requested information prior to the visit, please plan to arrive 30-45 minutes prior to your scheduled time.

Please arrive to your visit prepared with the following items:

- Completed Registration Paperwork (hard copy if emailed)
- Insurance Card(s) or proof of insurance
- Photo identification
- All Medical Records pertaining to the body part for which you are being treated
- MRI images and report(s), X-ray (s), Operative Report(s), Clinic Note(s)

Thank you and please feel free to contact me directly with any questions you may have!

*Amanda Peña*


**Practice Coordinator**
970.479.5881 DIRECT
970.476.1100 MAIN
970.237.4218 FAX
amanda@thesteadmanclinic.com
**DRLAPRADE.COM**



181 W Meadow Dr., St. 400
Vail Colorado 81657
970.476.1100
TSCandSPRI.com


# 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

**Patient Name**

_____

## Patient History Form

*Please PRINT and fill out completely*

**Date of Birth:**_____ **Age:**_____ **Height:**_____ **Weight:**_____

**History of Injury**

**Is this related to a:** ☐Work Injury? ☐Sport Accident? Or ☐Motor Vehicle Accident? If So, What State?_____

**Which Body Part is Injured?**_____ ☐Right / ☐Left **Hand Dominance:** ☐Right / ☐Left

**Please list the Injury/Accident Date:**_____ **If Chronic list how long:**_____

**Please describe in your own words: (How the Initial Injury Occurred AND how it Limits Your Activity)**

_____

_____

**Please Rate Your Pain on a Scale of 1 to 10:** (10 being the most painful)

**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:** ☐Constant or ☐Occasional **Has it Been:** ☐Worsening ☐Stable ☐Improving

**Describe the Pain:** ☐Sharp ☐Dull ☐Aching ☐Stabbing ☐Throbbing ☐Sensitive to Touch

**Do you have Pain at Night?** ☐Yes / ☐No **Does the Pain Keep or Wake you from Sleep?** ☐Yes / ☐No (☐Keep ☐Wake)

**What Symptoms are You Experiencing?**

☐Locking ☐Catching ☐Giving Way/Instability ☐Popping ☐Grinding ☐Bruising ☐Numbness ☐Tingling
☐Pain ☐Weakness ☐Swelling Other (Please describe):_____

**What, If Anything, Makes Your Symptoms Better?**

☐Rest ☐Activity ☐Cold Therapy ☐Heat Therapy ☐Medication ☐Other (Please describe):_____

**What, If Anything, Makes Your Symptoms Worse?**

☐Inactivity ☐Exercise (describe):_____ Other (Please describe):_____

**What Treatment Have You Tried for this Injury?**

☐Nothing ☐Exercise ☐Ice ☐Decreased Activity ☐Bracing
☐Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started):_____
☐Physical Therapy (Date Started):_____ ☐Acupuncture(Date Started):_____ ☐Other: _____
☐Medications:_____ ☐Chiropractic(Date Started):_____

**Have You Seen Another Physician for This Injury?** ☐Yes / ☐No **Were You Referred?** ☐Yes / ☐No

**If Yes, Who/Where?** _____

**Are you Interested in Surgery for this Problem?** ☐Yes / ☐No / ☐Unsure

**Have You Had Any of the Following Tests/Studies?**

| Test | Date (Month/Year) | Facility? (Clinic/Hospital) |
|---|---|---|
| X-Ray | | |
| MRI | | |
| CT Scan | | |
| EMG/NCV | | |
| Discogram | | |
| EKG | | |
| Blood Tests | | |
| Other | | |

Recreational Activities: _____

Current, regular exercise program (if any): _____

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 ☐ CD of images

☐ 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.

**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 AND STEADMAN PHILIPPON RESEARCH INSTITUTE

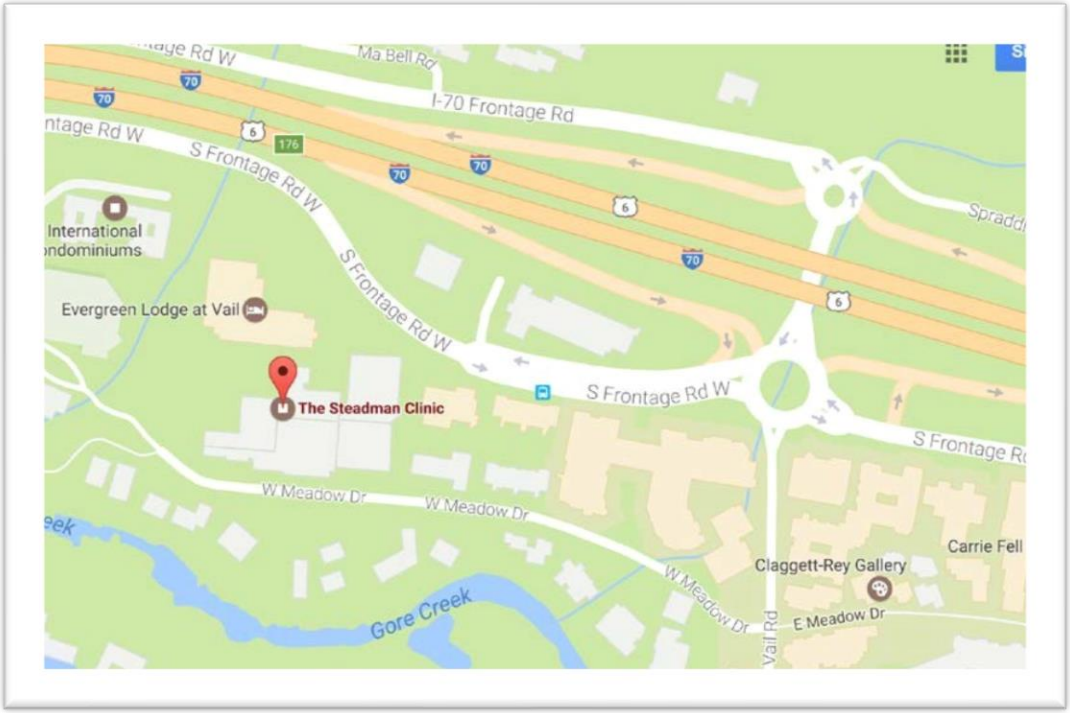
Directions – The Steadman Clinic Vail Location
181 West Meadow Drive, Suite 400
Vail, CO 81657
Phone: (970) 476-1100

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 second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Health. Parking attendants are available for drop-off assistance and valet parking upon request. Due to construction at Vail Health, free parking is also accessible at the town of Vail's Lionshead parking structure, just a short walk from Vail Health. The Steadman Clinic is located on the 4th floor of Vail Health. 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)

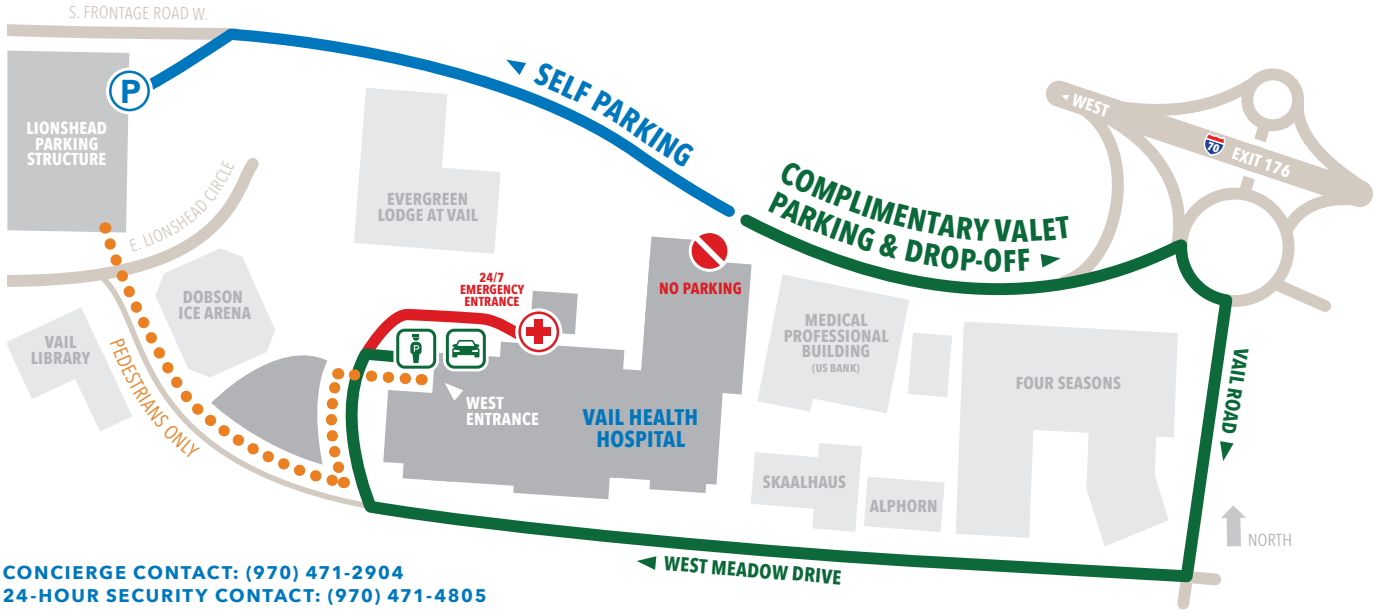
Exit the Eagle County Airport onto Cooley Mesa Road going East. At the stop light turn right (East) on Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Enter the roundabout and exit at the second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Health. Parking attendants are available for drop-off assistance and valet parking upon request. Due to construction at Vail Health, free parking is also accessible at the town of Vail's Lionshead parking structure, just a short walk from Vail Health. The Steadman Clinic is located on the 4th floor of Vail Health. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.



# HOSPITAL ACCESS

## DURING CONSTRUCTION

Complimentary valet parking and patient drop-off is available at the west entrance. Self parking is available in the Lionshead parking structure, and patients can then walk via the path designated below. Our apologies for the inconvenience.




**CONCIERGE CONTACT: (970) 471-2904**
**24-HOUR SECURITY CONTACT: (970) 471-4805**

- Vail Health Hospital Access
- Lionshead Parking Structure Access
- 24/7 Emergency Access
- Pedestrian Pathways
- Complimentary Valet Parking
- Patient Drop-Off

VAIL HEALTH