Steadman Hawkins Clinic Denver
Jennifer Kummer, MD
Hand & Upper Extremity Form

Practitioner's Initials:_____
Date:_______________

PATIENT HISTORY

Please print and fill out completely

Name:_______________________________________ Today's Date:_____________

Age:__________ Height:__________ Weight:__________

Hand Dominance: ☐ Left ☐ Right ☐ Both

Occupation:____________________ What activities do you enjoy?__________________

Family Physician:__________________________________ Phone:______________

Referring Physician:________________________________ Phone:______________

History of Present Illness (Why are you here today?)

Injury to: ☐ Left ☐ Right ☐ Both

Location: ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Other:______________

Did your problems result from a specific injury? ☐ Yes ☐ No Injury Date (mm/dd/yyyy):__________

Did your problems begin following: ☐ Work Injury ? ☐ Motor Vehicle Accident? ☐ Other?__________

How did you get injured?____

If neither, when did you first notice your symptoms?________________________________

Please rate your pain on a scale of 1 to 10 (10 being most painful):____________________

What, if anything, make your symptoms **better**?_______________________________________

What, if anything, make your symptoms **worse**?____

Since the onset of your symptoms, are you: ☐ Getting better? ☐ Getting worse? ☐ Staying the same?

Have you seen another physician for this injury? ☐ Yes ☐ No

If yes, who?__________________________________ Date:______________

What treatments have you tried? ☐ Nothing ☐ Hand Therapy ☐ Exercise ☐ Acupuncture ☐ Chiropractic ☐ Injections ☐ Medications______________________________

Have you had any of the following tests?

Test	Date (mm/yyyy)	What facility?
☐ x-rays	____________	____________
☐ MRI scan	____________	____________
☐ CT scan	____________	____________
☐ EMG/NCV	____________	____________
☐ Blood Tests	____________	____________
☐ Other	____________	____________

Patient Name:___________________________________

Past Surgical History

Please check any previous surgical procedures, list the date, and describe the surgery:

- ☐ Appendectomy
- ☐ Hernia Repair
- ☐ Upper Extremity Arthroscopy
- ☐ Lower Extremity Arthroscopy
- ☐ Spine/Back Surgery
- ☐ Heart Surgery
- ☐ Joint Replacement
- ☐ Fracture Repair

Other:____

____

Social History

Special Diet:	☐ Yes	☐ No	Any restrictions?______________________
Tobacco Use:	☐ Yes	☐ No	Type:__________ Duration:__________Quit Date:__________
Alcohol Use:	☐ Yes	☐ No	Frequency:______________________
Drug Use:	☐ Yes	☐ No	Frequency:______________________
Caffeine Use:	☐ Yes	☐ No	Frequency:______________________

Allergies

Are you allergic to any medications? **Sulfa:** ☐ Yes ☐ No **Latex:** ☐ Yes ☐ No ☐ No known drug allergies
Please list all medications that you are allergic to:______________________________
Please list food allergies (i.e., eggs, shellfish):______________________________

Medical History

- ☐ Anemia
- ☐ Depression
- ☐ Hepatitis A or B
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Rheumatoid Arthritis
- ☐ Asthma
- ☐ Emphysema
- ☐ HIV
- ☐ Stroke / Seizures
- ☐ Blood Clots
- ☐ Heart Disease
- ☐ Irregular Heartbeat
- ☐ Thyroid
- ☐ Cancer
- ☐ Liver Disease
- ☐ Chemical Dependency and/or Alcoholism
- ☐ Other

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

Medications

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include vitamins, minerals, and herb supplements.

Medication	Dosage	Frequency

Patient Name:________________________ Practitioner's Initials:______

Gastrointestinal History

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

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

Do you take any medications for your stomach? (Please include over the counter medications; ie Pepcid, Tums, Xantac, etc., also include the dosage and frequency)________________________

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include all over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex.) List all that you have tried:

____

Family History

Please check family history conditions:

◻ Blood Clots ◻ Diabetes ◻ Hypertension ◻ Rheumatoid Arthritis
◻ Cancer ◻ Heart Disease ◻ Osteoporosis ◻ Stroke / Seizures

Please describe any immediate family history of medical problems:________________________

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Review of Systems

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems, please check the negative/none box.

1. CONSTITUTIONAL GENERAL ◻ None ◻ Weight Loss ◻ Weight Gain ◻ Insomnia ◻ Chronic Fatigue ◻ Other________________________
2. EYES ◻ None ◻ Vision Change ◻ Glasses/Contacts ◻ Cataracts ◻ Glaucoma ◻ Other________________________
3. EARS, NOSE THROAT ◻ None ◻ Hearing Loss ◻ Seasonal Allergies ◻ Sinus Pain ◻ Ringing ◻ Other________________________
4. CARDIOVASCULAR ◻ None ◻ Chest Pain ◻ Edema ◻ Hypertension ◻ Palpitations ◻ High cholesterol ◻ Other________________________
5. RESPIRATORY ◻ None ◻ Asthma ◻ Wheezing ◻ Frequent Cough ◻ Other________________________
6. GASTROINTESTINAL ◻ None ◻ Heartburn ◻ Indigestion ◻ Acid Reflux ◻ Ulcer Problems ◻ Abdominal Pain ◻ Peptic Ulcer ◻ GI, Stomach Bleed ◻ Other__________
7. MUSCULOSKELETAL ◻ None ◻ Arthritis ◻ Muscle Weakness ◻ Joint Pain ◻ Back Pain ◻ Other________________________
8. SKIN ◻ None ◻ Rash ◻ Ulcers ◻ Scars ◻ Other________________________
9. NEUROLOGICAL ◻ None ◻ Headaches ◻ Seizures ◻ Numbness ◻ Dizziness ◻ Other________________________
10. PSYCHIATRIC ◻ None ◻ Depression ◻ Crying ◻ Anxiety ◻ Mood Swings ◻ Other________________________
11. ENDOCRINE ◻ None ◻ Diabetes ◻ Hypothyroid ◻ Hyperthyroid ◻ Other
12. HEMATOLOGY ◻ None ◻ Easy Bruising ◻ Bleeding ◻ Anemia ◻ Other________________________

Signature:________________________ Date:________________________
Print Name:________________________

Steadman Hawkins Denver Clinic

STATEMENT OF FINANCIAL RESPONSIBILITY

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 outpatient office charges at the time of the visit, unless other arrangements have been made. The Steadman Hawkins Denver Clinic will bill my insurance, provided all of the necessary information is given to the clinic. If any insurance company does not submit payment within 45 days, I understand that I will be responsible for any outstanding balance. I understand the Steadman Hawkins Denver Clinic will bill my insurance for any surgical charges, though I will be required to provide a deposit prior to the surgery based on an estimated financial responsibility.

NOTICE OF "NON-COVERED" SERVICES

I am aware that my insurance carrier or Medicare may consider some services performed by the Steadman Hawkins Denver Clinic "non-covered", therefore I will become fully responsible for payment of these services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE" CLAUSES

(For patients with "UCR" coverage) I acknowledge that the fees charged by Steadman Hawkins Denver 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 fees in full, even if the amount is greater than what I am reimbursed for from my insurance company.

☐

BILL TO/PAYMENT INSTRUCTIONS

Initial

I hereby authorize and request the Steadman Hawkins Denver Clinic to bill my insurance company for all services provided to me. I also authorize payment of medical benefits to the Steadman Hawkins Denver Clinic for any services provided to me and billed by the Steadman Hawkins Denver Clinic.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize the Steadman Hawkins Denver 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. This information must be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to the Steadman Hawkins Denver Clinic or its affiliates until written notice revoking it is provided.

I release the Steadman Hawkins Denver Clinic of all responsibility for loss of confidentiality through access and or copies made of records released in compliance to this authorization.

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

Patient's Name ____

Patient's or Legal Guardian's Signature: ______________________________ Date______________

If Legal Guardian, Relationship to Patient____

THE STEADMAN HAWKINS CLINIC DENVER

______________________________ ______________

Name of Patient (please print) **Date of Birth**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received The Steadman Hawkins Clinic Denver's Notice of Privacy Practices.

______________________________ ______________

Signature of patient or patient representative Date

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on __________ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:

____

____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):

____

____

______________________________ ______________

Signature of Employee Completing Form Date

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgment. The regulation does not specify how those "Good Faith Efforts" should be documented. This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]

Steadman Hawkins Clinic - Denver

Request for Confidential Communications Regarding Medical Information

I , _________________________,wish to request that the communication about my health and medical care, which contains Protected Health Information (PHI) , be communicated to me in the following manner:

(Please check how you would like to receive your Protected Health Information and provide the information we will need to send the information to you at your preferred location)

_____ By telephone at my home number:_______________________________

______ By telephone at a different number:____________________________

______ By FAX at this number provided:_______________________________

_____ By EMAIL at this email address:________________________________

______ By mail at an address other than the one on the record

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____

______Please do not leave messages regarding my PHI on my answering machine

_____ SHCD may leave an appointment reminder message on my answering machine

_____SHCD may discuss and/or leave messages about my PHI and/or accounting issues with the following individuals:

Name	Phone Number
Name	Phone Number
Name	Phone Number
Name	Phone Number

If you cannot be reached at the designated alternative location you specify, SHCD may use other means to contact you.

By signing this form, this communication request will remain in force until revoked in writing.

Printed Name	Signature	Month/Day/Year
Patient Account Name	Patient Account Number	Relationship to Patient
SHCD Employee	Signature	Month/Day/Year