IDAHO ORTHOPAEDIC AND SPORTS CLINIC
560 MEMORIAL DR.
POCATELLO, ID 83201
PHONE: (208) 234-1960 FAX: (208) 233-5033

Today's Date: _____ Referred By: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ M: ☐ F: ☐
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Social Security #: _____
Employer: _____ Work Phone: _____
Primary Care Doctor: _____ Phone Number: _____
Pharmacy:_____ Phone Number:_____
Reason for visit: _____ Left _____ Right_____

INJURY INFORMATION

Date of Injury: _____ On the Job? Yes ☐ No ☐ Auto Accident? Yes ☐ No ☐
How did the accident happen? _____
Location/State accident took place? _____

MEDICAL INFORMATION

Medical History (such as high blood pressure, diabetes, thyroid problems, heart troubles, ulcers, cancer etc.)

_____
_____

List all fractures and major injuries_____
Surgical History_____
_____

Medication Name	Medication Dose	What it is used for
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: _____
Any Other Allergies: _____
Do you use tobacco products? Yes ☐ No ☐ - if so how much? _____
Do you drink alcohol? Yes ☐ No ☐ - if so how much? _____

In blood relatives is there any history of:

	Yes	No		Yes	No		Yes	No
Tuberculosis	☐	☐	Heart Trouble	☐	☐	High Blood Pressure	☐	☐
Kidney Trouble	☐	☐	Birth Defects	☐	☐	Diabetes	☐	☐
Bleeding issues	☐	☐	Cancer	☐	☐	Mental Disorders	☐	☐

	Living	Deceased (age)	Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Other ___
Spouses Name: _____ Spouses Phone: _____

Emergency Contact: _____ Phone Number: _____

RESPONSIBLE PARTY

❑ Same as patient information

Name: _____ Date of Birth: _____ Age: ____ M: ___ F: ___
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Name of Policy Holder: _____
Policy Holders Date of Birth: _____ Policy Holders SSN: _____
Group #: _____ Policy #: _____
Insurance Address: _____ City: _____ State: ____ Zip: _____
Insurance Phone: _____

Secondary Insurance: _____ Name of Policy Holder: _____
Policy Holders Date of Birth: _____ Policy Holders SSN: _____
Group #: _____ Policy #: _____
Insurance Address: _____ City: _____ State: ____ Zip: _____
Insurance Phone: _____

I have read and agree to the Financial Policy of this office.

Signature: _____

I have read and agree to the Patient Notice of Privacy Practices of this office.

Signature: _____

I hereby give approval for photographs to be used for the records and medical teaching purposes.

Signature: _____

You may disclose my health information with the following person/facility:

Name: _____ Phone Number: _____

You may disclose my health information to this person: ☐ Always ☐ Specific Dates _____