Old Mill Medical Center:
6360 So. 3000 East, Suite 210
Salt Lake City, UT 84121

Albano Clinic

Joseph Albano, MD
Phone: 385-220-9009
Fax: 801-869-1987

Patient Health History/Subjective Information

____ ____/____/____ ________
Legal First Name   Legal Last Name   Middle Initial   Birth Date   Age

____ ____-____-____
Pharmacy Preference   **Pharmacy Address**   **Fax Number**

Reason for today's visit: ______________________________ Dominant Hand: Left ☐ Right ☐

How long have you been experiencing these problems? __________ Current Weight________ Lbs. Current Height______'_____"

Please List Any Medications You Are Currently Taking, Including Over-The-Counter Medications, Vitamins, etc.

.

Name of Medication	Dosage	How Often Taken	Are You Allergic to Any Medications?	
			Yes ☐ No ☐ If yes, please list them below.	
			Name of Medication	**Type of Reaction**

Hospitalizations, Surgeries or Serious Illnesses	Date

Treatments Attempted	No Relief - - Good Relief		
Bed Rest			
Physical Therapy			
Chiropractic			
Home Exercise or Home Health Service			
Heat or Cold Therapy			
Wearing a Sling, Brace or Orthotics			
Spinal or Muscle Injections			
TENS Unit			

Rate your pain by marking 0-10 on the scale below.
Zero (0) = No pain and Ten (10) = Extremely Intense Pain

0-----1-----2-----3-----4-----5------6------7-----8-----9-----10

Have you ever had any problems with Anesthesia?
Yes ☐ No ☐ If yes, please list problems below

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General Medical History

☐ Heart Disease	☐ Cancer/Tumor	☐ Asthma	☐ Ulcers or GI Bleeding	☐ Pregnant
☐ High Blood Pressure	☐ Diabetes	☐ HIV/AIDS	☐ Liver *or* Kidney Disease	☐ Pacemaker
☐ Heart Murmur	☐ Arthritis	☐ Hepatitis	☐ Osteoporosis	☐ Epilepsy
☐ Fibromyalgia	☐ Scoliosis	☐ Emphysema	☐ Thyroid Disorder	☐ Weight Loss/Gain
☐ Bleeding Disorder	☐ Tuberculosis	☐ Stroke	☐ Depression	☐ Circulation Problems

Review of Systems: Check all that apply

HEENT:	GI:	CV:	EXTREMITIES/MUSCULOSKELETAL:	HEMATOLOGY
☐ Difficulty Seeing	☐ Vomiting	☐ Irregular heartbeat	☐ Stiffness	☐ Anemia
☐ Eye Pain	☐ Diarrhea	☐ Heart murmur	☐ Back Pain	☐ Blood clot
☐ Change in Vision	☐ Bloody Stools	☐ Chest Pain on Exertion	☐ Diminished range of motion	☐ Easy Bruising
☐ Ringing in Ears	☐ Dark/tarry stools	RESPIRATORY:	☐ Swelling	☐ Easy Bleeding
☐ Hearing Loss	☐ Nausea	☐ Cough	☐ Pain	NEUROLOGY:
☐ Sore throat	ENDOCRINE:	☐ Pain with breathing	GU:	☐ Headache
☐ Runny nose	☐ Intolerant to Heat	☐ Wheezing	☐ Painful Urination	☐ Migraines
☐ Sinus Problems	☐ Intolerant to Cold	☐ Shortness of breath	☐ Bloody Urine	☐ Seizures
PSYCH	☐ Osteoporosis	SKIN:	☐ Urinate Frequently	☐ Stroke
☐ Depression	☐ Osteopenia	☐ Rash	☐ Awake at Night to Urinate	☐ Dizziness
☐ Anxiety	☐ Excessive Thirst	☐ Legions	NECK:	☐ Numbness
☐ Fatigue	☐ Excessive Hunger	☐ Lumps	☐ Neck or Thyroid Enlargement	☐ Weakness
☐ Drug Addiction	☐ Unusual Weight Gain	☐ Sores	☐ Other	☐ Other
☐ Alcohol Addiction	☐ Unusual Weight Loss	☐ Psoriasis	☐ Other	☐ Other

Social History

Use Tobacco? Yes ☐ **No** ☐	**Drink Alcohol? Yes** ☐ **No** ☐	**Marital Status:**
Packs per day ________________	**Drinks per day** ________________	Married ☐ Single ☐
For how long ________________	**Type (beer, Wine, Liquor, etc.)** ______________	Divorced ☐ Separated ☐
Quit date ____________________	**Quit date**________________________________	Widowed ☐ DP ☐

Occupation:

Work Status: ☐ **Working** ☐ **Unemployed** ☐ **Stay at home parent** ☐ **Retired** ☐ **Student**

☐ **Disabled - Due to:** ____

Employer: ____

Employer Phone: **Contact Name:**

Sports and activities, you like to do:

Signature ____**Date** ___________________

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Patient Demographics

Legal First Name ____ Legal Last Name ____ Middle Initial ____ Birth Date ___/___/___

Billing Address ____ Apt. # ____ City ____ State ____ Zip ____

Main Phone # ___-___-___ type *(Circle One)*: Cell Home Work

Additional Phone # ___-___-___ type *(Circle One)*: Cell Home Work

Social Security # ___-___-___ Race/Ethnicity ____ Gender *(Circle One)* Sex: M / F / T

*Primary care physician ____ Email address ____

Emergency Contact Information

Contact Name ____ Contact Phone # ___-___-___ Relationship to Patient ____

Contact Address ____ Apt. # ____ City ____ State ____ Zip ____

Responsible Party (if under 18 years of age)

Responsible Party's Legal Name ____ Birth Date ___/___/___ Relationship to Patient ____

Responsible Party's Address ____ City ____ State ____ Zip ____ Phone # ___-___-___

Insurance Information

Primary Insurance Company ____ Policy/Claim # ____ Group# *(If applicable)* ____ Effective date ___/___/___

Policy Holder's Name *(If not self)* ____ Policy Holder's Birth Date ___/___/___ Relationship to Patient ____

Secondary Insurance Company ____ Policy/Claim # ____ Group# (*If applicable)* ____ Effective date ___/___/___

Secondary Insurance Policy Holder's Name ____ Policy Holder's Birth Date ___/___/___ Relationship to Patient ____

Adjuster Name *(If workers compensation claim)* ____ Adjuster Phone # ___-___-___ Adjuster Fax ___-___-___

How did you hear about us? *Please be specific:*

- ☐ Family or Friend ____
- ☐ Internet (Please list Website/source) ____
- ☐ Referring Physician (Please print name) ____
- ☐ Print Ad (Please list where you saw the ad) ____
- ☐ Other (please explain) ____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Name of patient: ____

The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) of 1996 was created with the sole purpose and goal of protecting patient's medical records and financial information. We will not share this information without your consent. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I (patient/parent/guardian) authorize the staff of Heiden Orthopedics to release any:

☐ FINANCIAL INFORMATION ☐ MEDICAL INFORMATION

to the following people:

1. ____ 2. ____

3. ____ 4. ____

Albano Clinic will not release my medical information to individuals without a signed release form.

Signature ____Date _________________

FINANCIAL CONSENT

By signing below I agree to the following:

- **I will provide correct insurance information. Albano Clinic will bill my insurance company, my insurance company will directly pay Albano Clinic.**
- **To pay the allowable balance of medical bills after my insurance company has paid.**
- **To pay interest on all past-due amounts (>60 days)(at the rate of 18% per annum or 1.5% per month until paid in full).**
- **To pay any cost incurred to collect my payment, such as certified mail.**
- **To allow Albano Clinic to refer my unpaid account balance to a collection agency and to pay the collection fee up to 33% of the principal amount in addition to the principal amount. (Utah Code Annotated, sec. 12-1-11)**
- **The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility.**

Signature ____Date _________________