TBO PAPERWORK INSTRUCTIONS

***Please print paperwork in *Grayscale*.**
***Bring completed paperwork to your appointment along with your ID and insurance card.**

Form 1: Patient Incident Form
Please be sure to list **all** allergies, if none known please check box. Also remember to answer the specific question regarding a Latex Allergy.
If current problem is related to an accident, please select all that apply. If injury related, it is imperative that you write the date of injury. Your insurance may fight your claim, without the specific date.
Please list all medications you are currently taking, to include any vitamins or supplements. Should you run out of room, feel free to turn over this form and use the space on the back to continue listing medications. If you have a copy of your meds with you, we can make a photo copy and you may write in "see list" in the medications section.

Form 2: Patient Information
Please complete this entire form to include insurance information.

Form 3: Patient Consent Please sign all lines for medical consent. A printout of the TBO financial policy and privacy policy are available on our website or by request.

Narcotic Policy: Please read and sign/date.

Bubble Sheets: Despite the instructions on the top of the page, it is ok to use a **pen** on these sheets. Also you can neatly mark an "x" in the appropriate ovals, in lieu of coloring each oval in entirely.

Patient History: Please be sure to write in your name in the boxes provided at the top of the page then complete the form fully.

Patient/Family History: The top section is for **YOUR** personal medical history, the bottom for that of your **FAMILY**(parents, grandparents, siblings and children ONLY.) If you or your family members have been diagnosed with any other illness/disease not listed on this sheet, please notify your healthcare professional at the time of your appointment.

Surgical History: Please note the area at the top of the page to signify if you have **NOT** had any surgeries. If this pertains to you, please be sure to mark that bubble appropriately. If not, please mark all surgeries you have had.

Review of Systems: Please mark only the symptoms you are **CURRENTLY** experiencing. **It is imperative that you complete each section by marking all that apply---if no symptoms please mark "none" in each suitable section.**

Males: Do not mark in the Female Genitourinary section. **Please leave the "none" blank in this section.**

Females: Do not mark in the Male Genitourinary section. **Please leave the "none" blank in this section.**

Please feel free to ask for help at any time! We are more than happy to assist you!

Thunder Basin Orthopaedics and Sports Medicine

Mark G. Murphy, MD * Joseph F. Allegretto, MD * Mark Ryzewicz, MD
Robert J. Woodruff, MD * Dan A. Nicholls, PA-C * Tristyn Richendifer, PA-C

Today's Date:_____

Patient's Legal Name:_____ Date of Birth:_____

☐ **No known allergies or drug allergies (please check when none are known)**

Allergies:	**Type of Reaction: (i.e. hives, nausea)**

*****Do you have a Latex allergy?** ☐ **YES** ☐ **NO**

Why are you seeing the doctor today? ☐ Left ☐ Right ☐ Both _____(body part)

Is this visit for an injury? ☐ Yes ☐No **DATE of Injury:_____** Time of Day:_____am pm

Where were you when the injury occurred?_____

How did the injury occur? (Please be as specific as possible.)_____
_____
_____

Current problem is the result of a(n): (Check all that apply)

☐ Car Accident ☐ ***Work Accident** ☐ Accident ☐ Other_____

***If a result of a work accident, have you filed a claim with Workers' Comp?** ☐**Yes** ☐ **No**

***Out of state Workers' Compensation patients will be responsible for any remaining balance not covered by their Workers' Comp. If you are claiming Workers' Comp for Wyoming or any other state, please initial that you understand the above statement. _____**

Brief description of the symptoms you are experiencing (i.e. pain, popping, swelling)_____

Current Medications: (Please include Herbal Supplements and Vitamins)

Medications:	**Dose:**	**How Long?**	**Side Effects:**

Have you ever had general anesthesia? ☐ YES ☐ NO
Have you ever had problems with general anesthesia? ☐ YES ☐ NO (Describe):_____
Any personal or family history of malignant hyperthermia? ☐ YES ☐ NO

I give the medical staff of Thunder Basin Orthopaedics permission to examine me and make recommendations while under their medical care.

_____

Signature Relationship to Patient Date

☐ Please do not discuss my medical information with anyone except myself.

☐ I give Thunder Basin Orthopaedics permission to give information on my medical condition and treatment to:

_____ Relationship _____

☐ I give permission to my employer to attend my office visit(s).

☐ I give TBO permission to give information and medical documentation to my employer.

_____

Signature Patient Name Date

I acknowledge that I have been given a written copy of Thunder Basin Orthopaedics & Sports Medicine's privacy policies regarding my personal health information.

_____

Signature Relationship to Patient Date

I have read, understand, and agree to the attached Financial Policy. I understand that the charges not covered by my insurance company, as well as applicable co-payment and deductible are my responsibility.

_____

Signature Patient Name Date

I attest that the information that I have given is correct and true to the best of my knowledge. I hereby assign benefits to Thunder Basin Orthopaedics & Sports and authorize them to furnish health information regarding me to my insurance carrier. I understand that I am responsible for any amount not paid by my insurance.

_____

Signature Relationship to Patient Date

Thunder Basin Orthopaedics and Sports Medicine

Mark Murphy, MD * Joseph Allegretto, MD * Mark Ryzewicz, MD
Robert J. Woodruff, MD * Dan Nicholls, PA-C * Tristyn Richendifer, PA-C

~ Patient Information and Consent ~

Please complete this entire form and present your insurance card when registering.

Last Name _____ First Name _____ MI _____

Mailing Address _____ City_____ State _____ Zip _____

Physical Address _____ City_____ State _____ Zip _____

Phone: _____Cell_____ DOB _____ Age_____ Sex ___

Email _____

Marital Status _____ Social Security Number _____ Student ☐ Yes ☐ No

Primary Physician _____ Pharmacy Preference _____

How did you hear about us? _____

Referred by _____

Emergency contact not living with you _____ Phone _____

Patient's Employer

Employer _____ ☐ Full Time ☐ Part Time

Occupation _____

Address _____

City _____ State _____ Zip _____ Phone _____

Guarantor Information—Person Responsible for Medical Expenses

Name_____ Relationship _____

Social Security Number _____ Date of Birth _____ Phone _____

Mailing Address: _____

City _____ State _____ Zip _____ Phone _____

Employer _____ ☐ Full Time ☐ Part Time

Employer Phone _____

Primary Insurance

Company _____

Address: _____ City_____ State _____ Zip _____

Phone _____ Policy # _____ Group # _____

Policy Holder _____ DOB _____

Other Insurance

Company _____

Address: _____ City_____ State _____ Zip _____

Phone _____ Policy # _____ Group # _____

Policy Holder _____ DOB _____

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Today's Date: _____

Patient's Legal Name: _____
Date of Birth:_____

Any change in **YOUR** medical history since your last visit?-
_____
_____
_____

Any change in your **FAMILY** medical history since your last visit? _____
_____
_____
_____

Have you had any surgeries since your last visit? _____
_____
_____
_____

Height: _____ Weight: _____