Bear Lake Orthopeadics
Kerry G. Jepsen, M.D.

❖ Patient Information

Name (Last, First, Middle)	Employer
Local Address	Employer Address
City, State, Zip	City, State, Zip
Home Phone	Work Phone
Cell Phone	Emergency Contact
Social Security #	Address
Birth date	City, State, Zip
Sex Male Female	Phone

❖ Responsible Party Information (if Different than above)

Name (Last, First, Middle)	SSN	Birthdate	Sex
Local Address	Secondary/Billing (if Applicable)		
City, State, Zip	City, State, Zip		
Home Phone	Home Phone		
Relation To Patient			

❖ Primary Insurance

Name of Insurance Company	Policy #	
Name of Insured	Group #	
Address of Insurance Company	CoPay amount $	
City, State, Zip	Deductible $	
Relationship to Patient	Effective Date	Expiration Date

❖ Secondary Insurance (if Applicable)

Name of Insurance Company	Policy #	
Name of Insured	Group #	
Address of Insurance Company	CoPay amount $	
City, State, Zip	Deductible $	
Relationship to Patient	Effective Date	Expiration Date

Pharmacy ________________ Referred by ______________________________ Date of Injury__________________

Worker's Comp Case? YES / NO Workman's Comp Case #____________________________

I hereby assign all medical and/or surgical benefits to Bear Lake Orthopeadics. A photo copy of this is to be considered original. I understand that I am financially responsible for all charges. I hereby authorize said assignee to release all information necessary to secure payment.

____
Signature of Patient/Guardian

____
Date

CONSENT TO TREAT

I consent to and authorize Bear Lake Orthopeadic clinic to furnish me, and/or my dependents, with necessary medical care. This medical care may include radiology examination, laboratory testing and other diagnostic procedures as may be required.

RELEASE OF MEDICAL INFORMATION

I consent to and authorize Bear Lake Orthopeadic clinic to disclose all or part of my, or my dependents, medical records to my mutually agreed upon referring physicians.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I consent to and authorize Bear Lake Orthopeadic clinic to furnish medical information to any third party who may be responsible for payment of all or part of any charges incurred in this office.

I authorize my insurance company, or any responsible third party to pay benefits directly to the Bear Lake Orthopeadic clinic.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the payment of medical charges incurred on my or my dependent's behalf at the office of Bear Lake Orthopeadic clinic, regardless of third party coverage.

______________________________ ______________

Patient signature/Guardian **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I certify that I(or my Guardian) have received at copy of the Notice of Privacy Practices on behalf of Dr. K.G. Jepsen, M.D.,dba Bear Lake Orthopeadic clinic

______________________________ ______________

Patient signature/Guardian **Date**

MEDICARE AUTHORIZATION (if applicable)

I request that payment of authorized Medicare benefits be made on my behalf to Bear Lake Orthopeadic clinic. I authorize the holder of my medical information to release to the Health Care Financing Administration and its agents any information required to determine those benefits.

______________________________ ______________

Patient signature **Date**

Bear Lake Orthopeadic

Name -____ Date of Birth -______________

Date-__________ Phone- ______________ What are we seeing you for today? _______

____________________ How did it happen?____________________________________

Date of Injury ___________ X-rays taken? _____ Prior treatment? _______________

Primary Care Physician ___________ Referring Physician ______________________

Drug Allergies ____

Medications - ____

Hospitalizations/Surgeries -____

Please circle if you have a past medical history of the following:

Anemia	Anesthetic problems	Arthritis	Asthma
Blood clots	Cancer	Diabetes	Infections
Gout	Digestive disorders/Ulcers	Depression	Hepatitis
Heart problems	High blood pressure	Kidney Disease	Pneumonia
Osteoporosis	Tobacco use smoke/chew	Alcohol – Type /amount __________	
Women – Pregnant	*Planning pregnancy*	*Nursing*	

Family History

Please circle if you have a family history of the following:

Heart disease	High blood pressure	Cancer	Arthritis
Diabetes	Bleeding problems	Osteoporosis	

Other ____

Review of Symptoms

Please circle if you are now experiencing any of the following:

Fever/Chills	Vomiting	Diarrhea	Constipation
Night sweats	Bladder incontinence	Blood in stools	Numbness/Tingling
Palpitations	Abdominal pain	Chest pain	Joint pain
Wheezing	Bowel incontinence	Headaches	Shortness of breath

Other ____