NORTH IDAHO
ORTHOPEDICS & SPORTS MEDICINE

30544 Hwy 200, Ponderay, ID 83852
208-265-9817

WOODLANDS
FAMILY MEDICINE

Worker's Compensation Claim

PATIENT INFORMATION

Employer _____ Occupation _____

Work Phone _____ Supervisor's name _____

Primary Care Provider _____ (Please see receptionist if you do not have a Primary Care Provider or are looking for a Primary Care Provider)

Your Name _____ Soc. Sec. # _____
Last Name First Name Initial

Age _____ Birth Date _____ ☐Male ☐Female Phone _____

Mailing Address _____

Who should we notify in an emergency? _____ Phone _____

WORKER'S COMPENSATION INFORMATION

Was your injury reported to your employer? ☐ Yes ☐ No Claim Number_____

Date of Injury _____ Describe Injury _____

_____

Human Resource Contact_____ Phone Number_____ Fax Number_____

Adjustor's Name _____

☐ State Insurance Fund ☐ Sedgwick ☐ Gallagher Bassett (GBS) ☐ Intermountain Claims

☐ _____

If this claim is denied by Worker's Compensation Insurance or if you do not provide us a valid claim number within 14 days, this balance will be billed directly to you and/or your insurance company.

AUTOMOBILE INSURANCE - IF AUTOMOBILE ACCIDENT RELATED

Insurance Carrier Name _____ Insurance Phone _____

Insurance Billing Address _____ Adjustor Name _____

Date of Accident _____ Claim # _____

Patient's Name _____

PEOPLE AUTHORIZED TO RECEIVE INFORMATION

☐ Employer _____ Phone # _____

Name and Relationship to Patient _____ Phone # _____

Name and Relationship to Patient _____ Phone # _____

RESPONSIBILITY FOR PAYMENT

If this claim is denied by Worker's Compensation Insurance or if you do not provide us a valid claim number within 14 days, this balance will be billed directly to you and/or your insurance company.

MEDICATION REFILL POLICY

Please allow 48-72 business hours for medication refills. Please have your pharmacy fax the medication refill request. We will only prescribe pain medication for the acute post fracture, postoperative period and when necessary.

THERE WILL BE NO MEDICATION REFILLS DURING WEEKEND AND NON-BUSINESS HOURS.

ACKNOWLEDGEMENT AND AGREEMENT

Pend Oreille Orthopedic Urgent Care relies on the insurance and billing information provided to us by you or your referring provider. In the event that this information is not accurate a case deposit may be required, or your appointment may need to be rescheduled. After services are provided, we will submit our claim to your insurance carrier if applicable.

In the event that payment is denied, the patient is responsible for full payment. All patient balances are due within 30 days of the statement date. It is the patient's responsibility to contact the billing department if this obligation cannot be met.

Pend Oreille Orthopedic Urgent Care is committed to assisting our patients in meeting their financial responsibility; however, if arrangements are not made, we will utilize the services of a credit bureau or a collection agency. [Any fees associated with the services of these I hereby assign Pend Oreille Orthopedic Urgent Care all money due for medical and/or surgical services rendered by Pend Oreille Orthopedic Urgent Care in the event of a settlement.] I authorize Pend Oreille Orthopedic Urgent Care to send my medical information to my primary care provider and/or referring provider as necessary.

ASSIGNMENT: I HAVE READ, COMPLETED, AND FULLY UNDERSTAND THE ENTIRE PATIENT INFORMATION PACKET. I HEREBYAUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

_____ _____

Responsible Party Signature Date

Patient's Name _____

Dominant Hand ☐ Left ☐ Right

Injured/Affected Area ☐ Left ☐ Right ☐ Left & Right

☐ Elbow ☐ Wrist ☐ Hand ☐ Finger(s)
☐ Back ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Toe(s)

PAST MEDICAL HISTORY

Ongoing Medical Problems _____

_____

Prior Surgeries & Hospitalizations _____

_____

Current Medications and Dosages _____

_____

_____

☐ Allergies (Drug, Latex, Other) _____

☐ Do you have difficulties with anesthesia? _____

How much alcohol do you consume per week? _____

How much tobacco do you smoke/chew per day?_____ Number of years _____

Recreational drug use? _____

REVIEW OF SYSTEMS

Are you experiencing issues or problems of:

Fever	☐Y	☐N	Wheezing	☐Y	☐N	Fractures	☐Y	☐N
Weight Loss	☐Y	☐N	Asthma	☐Y	☐N	Sprains	☐Y	☐N
Weight Gain	☐Y	☐N	Sleep Apnea	☐Y	☐N	Joint Pain	☐Y	☐N
Fatigue	☐Y	☐N	Chest Pain or Pressure	☐Y	☐N	Joint Swelling	☐Y	☐N
Difficulty Sleeping	☐Y	☐N	Lower Extremities Swollen	☐Y	☐N	Arthritis	☐Y	☐N
Vision Changes	☐Y	☐N	Heart Palpitations	☐Y	☐N	Stiffness	☐Y	☐N
Double Vision	☐Y	☐N	High Blood Pressure	☐Y	☐N	Changes in Sensation	☐Y	☐N
Blurred Vision	☐Y	☐N	Irregular Heart Beats	☐Y	☐N	Low Back Pain	☐Y	☐N
Red or Burning Eyes	☐Y	☐N	Fainting	☐Y	☐N	Inability to move arms or legs	☐Y	☐N
Eye Trauma	☐Y	☐N	Abdominal Pain	☐Y	☐N	Coordination Problems	☐Y	☐N
Changes in Appetite	☐Y	☐N	Diarrhea	☐Y	☐N	Weakness	☐Y	☐N
Depression	☐Y	☐N	Constipation	☐Y	☐N	Balance	☐Y	☐N
Mood Change	☐Y	☐N	Urinary Hesitancy	☐Y	☐N	Memory	☐Y	☐N
Eye Glasses/Contacts	☐Y	☐N	Painful Urination	☐Y	☐N	Seizures	☐Y	☐N
Deafness	☐Y	☐N	Incontinence	☐Y	☐N	Hyperactivity or Hypoactivity	☐Y	☐N
Ringing in the ears	☐Y	☐N	Urgency/Frequency of Urination	☐Y	☐N	Hair Changes	☐Y	☐N
Hoarseness	☐Y	☐N	Bleeding Tendency	☐Y	☐N	Eczema	☐Y	☐N
Sinusitis	☐Y	☐N	Lymph Node Pain	☐Y	☐N	Sores that grow or don't heal	☐Y	☐N
Difficulty Swallowing	☐Y	☐N	Anemia	☐Y	☐N	Difficulty in speech	☐Y	☐N
Shortness of Breath	☐Y	☐N	Menstrual Abnormalities	☐Y	☐N	Balance	☐Y	☐N
Cough	☐Y	☐N	# Past Pregnancies	_____		Dizziness	☐Y	☐N
Coughing up Blood	☐Y	☐N				Hallucinations	☐Y	☐N
Changes in skin color, temperature, rashes, lesions, scars, masses			☐Y	☐N				

Patient's Name _____

REVIEW OF SYSTEMS - Pg 2

Check any family history of the following:

Diabetes	☐Y	☐N	Heart Disease	☐Y	☐N
Arthritis	☐Y	☐N	High Blood Pressure	☐Y	☐N
Stroke	☐Y	☐N	Problems with Anesthesia	☐Y	☐N
Cancer	☐Y	☐N	Cancer type: _____		

OSTEOPOROSIS REVIEW

Check any family history of the following:

Have either of your parents broken a hip after a minor bump or fall?	☐Y	☐N
Have you broken a bone after a minor bump or fall?	☐Y	☐N
Did you undergo menopause before age 45?	☐Y	☐N
Have you taken a corticosteroid tablet (prednisone, cortisone) for more than six months?	☐Y	☐N
Have you lost more than 2 inches (5cm) in height?	☐Y	☐N
Have your periods ever stopped for 12 months or more for reasons other than pregnancy or menopause?	☐Y	☐N
Do you regularly drink heavily?	☐Y	☐N
Do you suffer frequently from diarrhea (caused by problems such as coeliac disease or Crohn's Disease?	☐Y	☐N
Have you had surgery for obesity?	☐Y	☐N

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date