

Robert Gunderson, D.O.

PATIENT INFORMATION						
Patient's Last Name		First	Middle	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow	Referring Physician
Social Security Number	Mobile Phone ()	Other Phone ()		Birth Date / /	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Street/Mailing Address			City		State / Zip	
Email Address (required)		Spouse Name		Spouse Birth Date / /		Spouse Phone ()
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White			Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	
Are you: (check one) <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired		Employer			Employer Phone ()	
GUARANTOR (IF PATIENT IS A MINOR)						
Person Responsible for Charges		Birth Date / /	Social Security Number		Phone ()	
Address (if different)		Employer			Employer Phone ()	
INSURANCE INFORMATION PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST						
Is the patient covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> This injury is covered by Worker's Compensation						
PRIMARY Insurance Company Name: _____						
Who is the subscriber? <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other						
If the Patient is NOT the Subscriber:						
⇒ Subscriber's Name: _____ Subscriber's Birth Date: / / Subscriber's SSN: _____						
SECONDARY Insurance Company Name: _____						
Who is the subscriber? <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other						
If the Patient is NOT the Subscriber:						
⇒ Subscriber's Name: _____ Subscriber's Birth Date: / / Subscriber's SSN: _____						
IN CASE OF EMERGENCY						
Name of Local Friend or Relative (not living at same address)			Relationship to Patient		Phone ()	
HOW DID YOU HEAR ABOUT US?						
<input type="checkbox"/> Doctor <input type="checkbox"/> Attorney <input type="checkbox"/> Family / Friend <input type="checkbox"/> Hospital <input type="checkbox"/> Internet Search <input type="checkbox"/> Facebook <input type="checkbox"/> Other _____						
The above information is true to the best of my knowledge. I hereby authorize <i>Gunderson Orthopedics LLC</i> to administer treatment to the above patient. I also authorize payment directly to <i>Gunderson Orthopedics LLC</i> of the medical insurance benefits otherwise payable to me for medical services rendered. I understand I am financially responsible for any charges not covered by insurance.						
X _____			_____			
PATIENT OR LEGAL GUARDIAN SIGNATURE			DATE			

**Patient Privacy Notice
(Summary)**

Effective February 24, 2021

In accordance with the Federal Privacy Law (HIPAA), *Gunderson Orthopedics LLC* keeps medical information and records confidential and will only use them for patient treatment, health care operations, and billing purposes.

TREATMENT: Our physicians, clinicians, and staff will use your medical information to give you the best possible care.

HEALTH CARE OPERATIONS: *Gunderson Orthopedics LLC* will use this information for appropriate follow-up care, patient notification, statistical and regulatory requirements, and internal quality assurance programs.

BILLING PURPOSES: *Gunderson Orthopedics LLC* will use your medical information to bill the appropriate third parties for your care.

**DISCLOSURE OF INFORMATION WITH
EXTENUATING CIRCUMSTANCES**

1. Health information may be given to family members and/or friends in case of an emergency.
2. Health information may be given to other physicians or institutions, at the discretion of the physician, to facilitate diagnosis and treatment.
3. Information may be given to proper authorities when neglect or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is given to this office.

I understand that if I have any questions I can speak to the *Gunderson Orthopedics LLC* Privacy Officer. I also understand that a detailed version of the *Patient Privacy Notice* is available upon request.

I understand and agree to the above Privacy Policy:

Signature of Patient, Parent, or Legal Guardian

Date

Release of Medical Information To Others Involved in Your Healthcare

As stated in our *Patient Privacy Notice*, we cannot disclose to members of your family, your friends, or other acquaintances any protected health information that directly relates to your health care unless we have written permission from you. We request that you designate the individuals with whom we may discuss your protected health information. **Other persons calling about your appointment, billing, or direct health care issues will be refused access to this information.**

I give *Gunderson Orthopedics LLC* permission to discuss my protected health information with the following persons:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand that I may rescind or modify this permission at any time. Such changes must be in writing to *Gunderson Orthopedics LLC*.

Signature of Patient, Parent, or Legal Guardian

Date

I do not want my medical records, including appointment times, released to anyone including my work/school, spouse, family members, or attorney. _____ ***initial***

FINANCIAL AGREEMENT

1. We will file insurance claims for all covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance company's maximum allowable reimbursement. You will be responsible for any deductible or co-payment amounts and any non-covered services incurred at the time of service.
2. You are responsible for payment of all medical treatment and related services and supplies provided. If payment is not made as agreed, you shall be responsible for any and all interest (at 1.5% per month or 18% per annum), reasonable attorney fees, costs of collection and court costs incurred in efforts to enforce this agreement.
3. **If you have insurance but did not bring your insurance ID card(s)** you will be set up on a self-pay account and you must pay for your visit at the time of service or your appointment will be rescheduled. Any overpayment on your account will be refunded after your insurance pays.
4. **If your injury was due to a Motor Vehicle Accident** you will be set up on a self-pay account. Patients are expected to pay up to \$300.00 in charges incurred at the time of visit. Claims will be filed with third party insurance carriers on behalf of any patient who has provided complete and accurate billing information.
5. **There is a \$25.00 charge for the completion of any patient-requested form such as *Family Medical Leave Act (FMLA) forms, disability forms, etc.*** This charge is applicable per form and is payable prior to completion. Please allow 7-10 days for form completion.
6. If you need to re-schedule or cancel your appointment, please contact us 48 hours prior to your scheduled office visit or 72 hours prior to a scheduled procedure or surgery. If we are not notified **a no-show charge of \$50.00 for office visits or \$100.00 for procedures/surgeries will apply.**
7. We may occasionally communicate with you via text message (SMS or iMessage). You may opt out by responding with your request via text message.

In keeping with our commitment to serve our patients in need of financial assistance, we have secured arrangements for patient financing through Care Credit® for your convenience. Ask a staff member or visit www.carecredit.com for details.

I, the undersigned, in consideration of goods and/or services rendered pursuant to this agreement, do hereby personally, individually, and severally guarantee the full payment of all sums of money due and owing to **Gunderson Orthopedics LLC**. In addition, any sums of money that may become due and owing or past due according to the terms of this agreement shall be my responsibility.

Name: (Print) _____ Name: (Signature) _____

Date: _____

NARCOTICS POLICY

- The pain you are experiencing may be improved, but not eliminated, with the use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be refilled if you are unable to keep these appointments.
- Your treating physician is to be the only physician who prescribes narcotic pain medications to you. It is your responsibility to notify us of any other physician who is prescribing narcotic pain medication to you. It is also your responsibility to inform other physicians that we are prescribing and managing your narcotic pain medications.
- Excessive calls requesting pain medications or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
- Pain medication refill requests are handled Monday through Thursday from 8:30 AM to 3:30 PM ONLY. **PRESCRIPTION REFILL REQUESTS ARE NOT PROCESSED ON FRIDAY, SATURDAY, SUNDAY, HOLIDAYS OR AFTER HOURS FOR ANY REASON.** Prescription refills will be processed within 5 business days of the request.
- Lost, stolen, or misplaced narcotic prescriptions or medications ARE NEVER REPLACED – NO EXCEPTIONS. Your medications and prescriptions are your responsibility.

Thank you for allowing *Gunderson Orthopedics LLC* to participate in your care.

Sincerely,

Gunderson Orthopedics LLC Physicians and Staff

TODAY'S PROBLEM

Patient Name: _____

What is your current problem(s)? _____
Location: _____

Date of injury: _____ OR Date symptoms began: _____

How did the injury occur? _____

Current severity of a scale of 1-10: _____ Type of pain: _____

Associated Symptoms (circle): numbness radiating pain burning change in temperature change in color

Were you injured **on the job**? Yes No

Has a Worker's Compensation Claim been filed? Yes No

Were you injured in an accident? Yes No

Motor vehicle Yes No

Third party liability Yes No

Are you represented by an attorney? Yes No

Attorney name: _____

Attorney phone #: _____

Have you been treated before for this injury? Yes No

If Yes, describe the treatment: _____

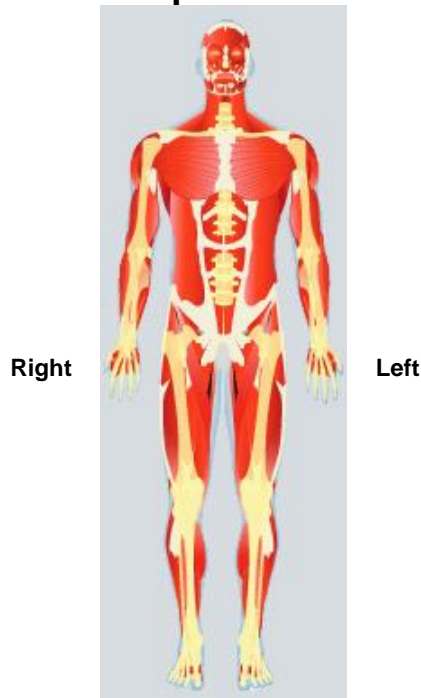
Were x-rays, MRI scans, or other tests done? Yes No

Did you bring films or a report with you? Yes No

Are you here for a second opinion about surgery? Yes No

ARE YOU IN PAIN MANAGEMENT? Yes No

Please circle the location of pain we are seeing you for today.



Are you able to continue activity or work? Yes No

MEDICAL HISTORY

Height: ____ feet ____ inches Weight: ____ pounds Occupation: _____

ALLERGIES (check all that apply) No allergies _____ *initial*

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Accupril (quinapril)
<input type="checkbox"/> Acetaminophen/Tylenol
<input type="checkbox"/> Acyclovir
<input type="checkbox"/> Advil (ibuprofen)
<input type="checkbox"/> Altace (ramipril)
<input type="checkbox"/> Ampicillin
<input type="checkbox"/> Amaryl (glimepiride)
<input type="checkbox"/> Augmentin (amoxicillin)
<input type="checkbox"/> Aspirin
<input type="checkbox"/> Bactrim (sulfamethoxazole)
<input type="checkbox"/> Biaxin
<input type="checkbox"/> Carafate (sucralfate)
<input type="checkbox"/> Ceclor (cefaclor)
<input type="checkbox"/> Celebrex
<input type="checkbox"/> Cephalosporins
<input type="checkbox"/> Cipro (ciprofloxacin)
<input type="checkbox"/> Clinoril (sulindac)
<input type="checkbox"/> Contrast media (ioversol)
<input type="checkbox"/> Codeine
<input type="checkbox"/> Coumadin
<input type="checkbox"/> Darvon | <input type="checkbox"/> Demerol
<input type="checkbox"/> Depakote
<input type="checkbox"/> DiaBeta (glyburide)
<input type="checkbox"/> Diamox
<input type="checkbox"/> Dicloxacillin
<input type="checkbox"/> Doxycycline
<input type="checkbox"/> Egg
<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Famotidine
<input type="checkbox"/> Flagyl
<input type="checkbox"/> Floxin
<input type="checkbox"/> Glucotrol (glipizide)
<input type="checkbox"/> heparin
<input type="checkbox"/> Ibuprofen
<input type="checkbox"/> Inderal (propranolol)
<input type="checkbox"/> Indocin (indomethacin)
<input type="checkbox"/> Insulin (animal)
<input type="checkbox"/> Iodine or Shellfish
<input type="checkbox"/> Keflex (cephalexin)
<input type="checkbox"/> Klonopin
<input type="checkbox"/> Lasix (furosemide) | <input type="checkbox"/> Latex
<input type="checkbox"/> Levofloxacin
<input type="checkbox"/> Lidocaine
<input type="checkbox"/> Lipitor
<input type="checkbox"/> Lodine
<input type="checkbox"/> Lopressor (metoprolol)
<input type="checkbox"/> Lortab/Hydrocodone
<input type="checkbox"/> Micronase (glyburide)
<input type="checkbox"/> Minocin (minocycline)
<input type="checkbox"/> Morphine
<input type="checkbox"/> Motrin (ibuprofen)
<input type="checkbox"/> Naprosyn (naproxen)
<input type="checkbox"/> Neptazane
<input type="checkbox"/> Niacin
<input type="checkbox"/> Peanut
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Percocet (oxycodone)
<input type="checkbox"/> Persantine
<input type="checkbox"/> Plavix
<input type="checkbox"/> Phenytoin
<input type="checkbox"/> Pravachol | <input type="checkbox"/> Prevacid
<input type="checkbox"/> Prilosec
<input type="checkbox"/> Prinivil
<input type="checkbox"/> Quinolones
<input type="checkbox"/> Ranitidine
<input type="checkbox"/> Septra (sulfamethoxazole)
<input type="checkbox"/> Sulfa
<input type="checkbox"/> Tagamet (cimetidine)
<input type="checkbox"/> Tegretol (carbamazepine)
<input type="checkbox"/> Tenormin (atenolol)
<input type="checkbox"/> Tetanus toxoid
<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Ticlid
<input type="checkbox"/> Valium (diazepam)
<input type="checkbox"/> Vancomycin
<input type="checkbox"/> Vasotec
<input type="checkbox"/> Zestril
<input type="checkbox"/> Zithromax
<input type="checkbox"/> Zocor (simvastatin)
<input type="checkbox"/> Zylprim (allopurinol)
<input type="checkbox"/> Other: _____ |
|---|--|--|--|

REVIEW OF SYSTEMS (check all that apply) All are normal _____ *initial*

- | | | | |
|---|---|---|---|
| Constitutional | Cardiovascular | Skin | Metabolic / Endocrine |
| <input type="checkbox"/> Chills
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fever
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weakness
<input type="checkbox"/> Weight gain
<input type="checkbox"/> Weight loss
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Chest pain
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Water retention/swelling
<input type="checkbox"/> Syncope (fainting)
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Contact allergy
<input type="checkbox"/> Itchy skin
<input type="checkbox"/> Rash
<input type="checkbox"/> Skin infections
<input type="checkbox"/> Skin lesions
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Cold intolerant
<input type="checkbox"/> Hair loss
<input type="checkbox"/> Heat intolerant
<input type="checkbox"/> Other: _____ |
| Head/Eyes/Ears/Nose/Throat | Gastrointestinal | Neurological | Psychiatric |
| <input type="checkbox"/> Blurred vision
<input type="checkbox"/> Double vision
<input type="checkbox"/> Trouble Speaking
<input type="checkbox"/> Headache
<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Vision loss
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Constipation
<input type="checkbox"/> Black tarry stools
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Jaundice/Yellow eyes, skin
<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Seizures
<input type="checkbox"/> Dizziness/ Vertigo
<input type="checkbox"/> Poor coordination
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Paresthesia/Numbness
<input type="checkbox"/> Tremors
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Mental Illness _____
<input type="checkbox"/> PTSD
<input type="checkbox"/> Other: _____ |
| Respiratory | Genitourinary | Immunological | |
| <input type="checkbox"/> Chest pain (respiratory)
<input type="checkbox"/> Cough
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Recent infections
<input type="checkbox"/> Known TB exposure
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Pain with urination
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Hematuria/Blood in Urine
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Asthma
<input type="checkbox"/> Bee sting allergies
<input type="checkbox"/> Contact dermatitis
<input type="checkbox"/> Environmental allergies
<input type="checkbox"/> Food allergies
<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Other: _____ | |

PAST MEDICAL HISTORY (check all that apply) No major illness _____initial

- Aids/HIV
- Alcoholism
- Alzheimer's
- Anemia
- Angina
- Arthritis
- Asthma
- Atrial fibrillation
- Benign prostatic hypertrophy
- Cancer _____
- CVA/Stroke
- Congestive heart failure
- COPD
- Coronary artery disease
- Crohn's disease
- Degenerative joint disease
- Depression
- Diabetes _____
- Drug abuse
- DVT / Blood Clot
- Fibromyalgia
- Gall bladder disease
- GERD/Heartburn
- Gout
- Hepatitis
- High Cholesterol
- Hypertension
- Inflammatory bowel disease
- Juvenile rheumatoid arthritis
- Kidney disease
- Liver disease
- METAL IN YOUR BODY**
- Migraine headaches
- Multiple sclerosis
- MI / Heart Attack
- Obesity
- Osteoarthritis
- Osteoporosis
- Parkinson disease
- Peptic ulcer disease
- Psoriasis
- PVD/Circulation Problems
- Renal disease
- Rheumatoid arthritis
- Scoliosis
- Seizure disorder
- Sleep apnea
- SLE / Lupus
- Spinal stenosis
- Spondyloarthropathy
- Thyroid disease
- Valvular disease
- Other _____

PAST SURGICAL HISTORY (check all that apply) No past surgeries _____initial

- ACL surgery
- Angioplasty
- Angio w/stent
- Appendectomy
- Arthroscopy ankle
- Arthroscopy elbow
- Arthroscopy hip
- Arthroscopy knee
- Arthroscopy wrist
- Arthroscopy shoulder
- Back surgery
- CABG/Heart Bypass
- Cardiac valve replacement
- Carpal tunnel release
- Cataract extraction
- Gallbladder Removal
- Colonoscopy
- Discectomy
- Gastric bypass
- Hernia repair
- Hip arthroplasty
- Hip replacement
- Knee replacement
- Laminectomy
- LASIK
- Meniscus surgery
- Muscle biopsy
- ORIF/Fracture Repair
- PACEMAKER**
- Small bowel resection
- Thyroidectomy
- Tonsillectomy
- Cesarean section
- Hysterectomy
- Tubal Ligation
- Mastectomy
- Other _____

FAMILY HISTORY (check all that apply)

- ADD/ADHD
- Alcoholism
- Allergies
- Alzheimer's Disease
- Anemia
- Asthma
- Blood disease
- Cancer Bone
- CAD/Coronary Artery Disease
- Cancer _____
- Colitis
- Congenital heart disease
- Congestive heart failure
- COPD
- CVA (stroke)
- Depression
- Developmental delay
- Diabetes _____
- Drug abuse
- Gout
- Hearing impairment
- Heart disease
- Hodgkin's disease
- Hypertension
- Kidney disease
- Learning disability
- Liver disease
- Mental illness
- Migraines
- Muscle disease
- Obesity
- Osteoarthritis
- Osteoporosis
- Parkinson's
- PVD/Circulation Problems
- Renal disease
- Seizure disorder
- Thyroid disorder
- Other: _____

SOCIAL HISTORY

Hand dominance? Left Right

Are you pregnant? Yes No

Do you smoke? Yes No Formerly

Drink Alcohol? Yes No Formerly

