IASIS HEALTHCARE | Physician Group of Utah
EMPLOYED PHYSICIAN GROUPS

Date: _____

Physician/Provider being seen today: _____

PATIENT INFORMATION

Patient Last Name	First Name	Middle Name

Gender M F	DOB / /	Social Sec. #	Cell Phone	Home Phone

Address	City	State	Zip

Occupation	Employer	Business Phone

Employer Address	City	State	Zip

Driver License #	Email Address : *I would prefer not to receive periodic health information.* ☐	Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated

Race and ethnicity questions are asked in order to identify additional care needs of our diverse patient population and is not used to discriminate in any manner. ☐ Multiracial ☐ Other

Race ☐ Hispanic or Latino ☐ Non-Hispanic or Latino **Ethnicity** ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native

Preferred Language	Name and Address of Referring Physician

Emergency Contact Information (Full Name/Relationship to Patient):	Phone (REQUIRED)

Authorization for telephone, cell phone and/or electronic communications:
I authorize the Physician Group of Utah and all third-party providers and practitioners who provide health care services to me, along with their billing and collection agents to contact me on my cell phone and/or home phone, including through the use of pre-recorded messages, artificial voice messages, automatic telephone dialing services, or other computer assisted technology, or by electronic mail, text messaging or any other form of electronic communication for the purposes of payment for services or for health care related notice. ☐ Agree ☐ Decline

RESPONSIBLE PARTY INFORMATION

Relationship To Patient	Last Name	First Name	Home Phone

Billing Address	City	State	Zip

Social Sec. #	Date of Birth	Employer	Business Phone

Employer Address	City	State	Zip

Spouse First Name (and last if different)	Employer	Phone

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES)

Primary Insurance Company	Co-pay Amount	Policyholder Name	/ /	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Company Address	Effective Date:	Phone

Policy #	Group #	Group Name

2nd Insurance Company	Co-pay Amount	Policyholder Name	/ /	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Company Address	Effective Date:	Phone

Group #	Policy #	

INJURY INFORMATION (MUST BE FILLED OUT COMPLETELY)

Reason for Visit?	What type of injury are we seeing you for? (indicate right or left if appropriate)

Was this an: ☐ Accident ☐ Injury	Date of accident or injury / /	Place of Accident: ☐ Work ☐ Auto ☐ Home ☐ School ☐ Other: _____

Name of School	Sport/Activity	How was injury sustained?

Is this employment related? Yes ☐ No ☐ If so, who is your company's industrial carrier?	Claim Number

Name of Address of Place of Injury:	Adjuster Name and Phone Number

Patient name: Last, First, MI	Date of birth mm/dd/yyyy	Medical Record #

As either the Patient or the legally authorized representative of the Patient, on behalf of the Patient receiving care in this Physician Group of Utah (PGU) Facility, I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient. In partial consideration of health care services to be provided to the Patient in the PGU Facility, including IASIS Healthcare and its affiliates.

CONSENT FOR SERVICES: I hereby give consent to the Facility, its contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for services they perform.

INDEPENDENT CONTRACTORS: I understand that some physicians and other health care providers furnishing service to the Patient, including residents, interns and other persons in training may be independent contractors and not employees of PGU; and such employees are subject to provisions of the Utah Governmental Immunity Act, UCA 63-30-1, et seq., U.C.A. 1953 as amended, which controls all procedures and provisions with respect to any claim of liability or malpractice involving such individuals.

ASSIGNMENT OF BENEFITS: Any and all benefits from insurance companies and other third party payors that are payable to the Patient or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the Facility for the exclusive purpose of paying for charges associated with the health care services provided to the Patient in the Facility. I understand and intend that all insurance companies and other third party payers will pay benefits directly to the Facility in payment of the Facility's charges and the charges of any other health care providers for whom the Facility is authorized to bill in connection with health care services provided to the Patient.

FINANCIAL RESPONSIBILITY: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to the Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patient and the undersigned, if other than the Patient, remain responsible for all copayments, deductibles, co-insurance, and/ or non-covered services regardless of amount paid by insurance or third party payor. I understand and agree than any amounts not paid within 30 days of the date of the Facility's bill or statement for payment shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay a 20% collection fee, all costs and reasonable attorney's fees in connection with the collection process. As a courtesy to our personal pay patients, a discount is extended for specified services. The largest discount is available when services are paid in full on the date of service. Please ask about any discounts that may be available.

MEDICARE/MEDICAID/TRICARE PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

RELEASE OF INFORMATION: The Facility is required by law to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice Of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

The undersigned signs this document either as the Patient or the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing act. This document will remain in effect unless revoked in writing.

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 patients' medical records and financial information. 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 authorize the staff of Physician Group of Utah, Inc. to release any FINANCIAL INFORMATION to the following people:

_____

_____

_____

I authorize the staff of Physician Group of Utah, Inc. to release any MEDICAL INFORMATION to the following people:

_____

_____

_____

I authorize the staff of Physician Group of Utah Inc. to leave laboratory or radiology tests results on my voice mail at the following telephone numbers:

HOME:_____

CELL:_____

NOTIFICATION OF PHYSICIAN OWNERSHIP

You may be referred for an ancillary service at one of our IASIS Utah hospitals or facilities. A number of our physicians have ownership in one of our IASIS hospitals. We want you to know you are free to choose where you go for your healthcare services that are delivered outside our clinic.

You were previously given a document explaining our physician ownership and listing those physicians who are owners. That document is saved in your personal health record. If you would like to review this document or receive more information, please ask a reception staff member.

Patient initial here: _____

DATE: _____ SIGNATURE: _____

WITNESS TO SIGNATURE: _____ RELATIONSHIP IF OTHER THAN PATIENT: _____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED OR BEEN OFFERED A COPY OF PGU'S NOTICE OF PRIVACY PRACTICE.
DATE: _____INITIALS: _____

CENTER OF ORTHOPEDIC AND REHABILITATION EXCELLENCE

Patient Name: _____ DOB: _____

Use of narcotic pain medication can produce dangerous side effects and potentially cause addiction if used for extended periods of time. Narcotic pain medications are used in this clinic for treatment of acute or short-term pain such as the pain experienced after an injury or surgery. The amount of narcotics taken for any condition will be limited in order to prevent the body from building up a tolerance to the medications. Your physician will prescribe enough medication to last through a weekend or holiday period so refills can be given during normal office hours. If you require pain medications for longer than 1-2 months post op, or 3 months post op for spine, you will be referred to a pain clinic.

If you are receiving pain medications from multiple doctors, we will discontinue prescribing pain medications for you and may dismiss you from our practice. If pain medications are used up at a faster rate than they have been prescribed, no more refills will be given until the prescription time has elapsed.

You are encouraged to use non-narcotic pain medications such as ibuprofen, Tylenol, other anti-inflammatory or analgesic medications. It is important to remember that other techniques may be used in place of narcotics for symptoms and control such as ice/heat, massage, deep breathing and relaxation techniques, and over–the-counter medications such as Extra Strength Tylenol, etc. You should check with your physician's assistant prior to starting any over-the-counter medications.

If any side effects from the prescription occurs, the patient should notify his or her physician's assistant. Medication refill requests must be faxed from your pharmacy before 3:00 PM Monday-Thursday and before 10:00 AM on Friday. Some medications such as Percocet or Oxycodone require a written prescription and can't be called into the pharmacy. Prescriptions for these medications will only be filled when we are in the office. We require a minimum of 24 hours to refill all medications. Prescription refills will not be issued after these hours or on weekends by the on-call physician. THIS IS OUR OFFICE POLICY AND NO EXCEPTIONS WILL BE MADE!

Patient's signature indicates that the above policy has been explained to the patient, and the patient understands and agrees to the policy.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Physician Group
OF UTAH, INC.

MEDICAL AND FINANCIAL INFORMATION AUTHORIZATION AND RELEASE

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 patients' medical record and financial information. We appreciate your attention to this sensitive matter. Please be specific when designation your choices.

I authorize the staff of Physician Group of Utah, Inc. to release any **FINANCIAL INFORMATION** to the following people:

SPOUSE: _____

PARTNER: _____

PARENT/GUARDIAN: _____

OTHER: _____

I authorize the staff of Physician Group of Utah, Inc. to release any **MEDICAL INFORMATION** to the following people:

SPOUSE: _____

PARTNER: _____

PARENT/GUARDIAN: _____

OTHER: _____

I authorize the staff of Physician Group of Utah, Inc. to leave **LABORATORY OR RADIOLOGY TEST RESULTS** on my voicemail at the following telephone numbers:

Home Number: _____ Mobile Number: _____

Other Number: _____

_____ _____
Patient Name Date

_____ _____
Signature of Patient/Guardian/Personal Representative Date

Dear Patient:

A number of our physicians are proud owners of an IASIS hospital in Utah, which are physician-owned hospitals under 42 U.S.C. §1395nn. At the time of a referral for any necessary hospital services, each of our patients may choose to receive those services at an IASIS hospital or any other facility, center or hospital for the purpose of having such services performed as determined by the patient to be in the patient's best interest.

Below is a list our physicians who have ownership in an IASIS Utah hospital.

Davis Hospital & Medical Center

Allen Francis	Davis Internal Medicine
William Hughes	Rocky Mountain Women's Health Center - Layton
Charles Joseph	Rocky Mountain Women's Health Center - Layton
Matthew Lyman	Davis Orthopedics & Sports Medicine
Maria Hernandez	Rocky Mountain Women's Health Center - Layton
B. Thomas Watson	Davis Orthopedics & Sports Medicine
Craig Julien, MD	Legacy Point Family Medicine

Jordan Valley Medical Center, Jordan Valley Medical Center – West Valley

Charlie Marshall	C.O.R.E. - West Jordan
Chris Valentine	Sandy Ridge Family Medicine
Jack Szwajkun	Heart & Lung Institute of Utah
Armen Khachatryan	C.O.R.E. - West Jordan
Charles Beck	C.O.R.E. - West Jordan
Dennis Gordon	C.O.R.E. - West Valley
Doug Burrows	C.O.R.E. - West Valley
Kevin Johnson	Jordan Valley Internal Medicine
Les Harris	C.O.R.E. - West Jordan

Salt Lake Regional Medical Center

Drew Cooper	Comprehensive Orthopedics & Sports Medicine
David Howe	Comprehensive Orthopedics & Sports Medicine
David Nathan	Neuroscience & Rehabilitation Specialists - SLRMC
Elena James	Neuroscience & Rehabilitation Specialists - SLRMC
Jim Stringham	Heart & Lung Institute of Utah
Mark Brann	Heart & Lung Institute of Utah

We ask that you acknowledge receipt of this information by signing below.

Signed by the patient:

_____ _____

Signature *Date*

CENTER OF ORTHOPEDIC AND REHABILITATION EXCELLENCE

Occurrence Form

Patient's Name: _____ **Today's Date:** _____

Date of Birth: _____ **Male / Female** (Circle one) **Date of Injury:** _____

WHICH PART of the body, and **LOCATION** on the body [L, R, Bilateral, C- T- L- Spine]) HAS BEEN AFFECTED?

_____

WHAT CAUSED THIS PROBLEM TO OCCUR?_____

_____

WAS THIS FROM AN INJURY THAT IS **WORK** RELATED? **YES / NO** **AUTO** RELATED? **YES / NO**

IF YOU HAVE ALREADY RECEIVED INITIAL TREATMENT FOR THIS CONDITION:

- **WHAT FACILITY** TREATED YOU? _____
- **WHICH PHYSICIAN** TREATED YOU? _____
- WHAT **DIAGNOSTICS** HAVE YOU RECEIVED? ❒ X-RAY ❒ CT ❒ MRI
  WHERE? _____ WHEN? _____
- WHAT **RECORDS** DID YOU BRING WITH YOU TODAY? (Example: X-RAY FILMS, CD OF MRI)
  _____
- IF YOU ARE UNABLE TO GIVE A SPECIFIC DATE OF OCCURRENCE, HOW LONG HAVE YOU BEEN EXPERIENCING SYMPTOMS? (DAYS, WEEKS, MONTHS) _____

****ANSWER THE FOLLOWING *ONLY* IF YOUR INJURY IS WORK- OR AUTO-RELATED:****

HAVE YOU FILED A CLAIM? YES / NO

IF THE ANSWER IS NO, PLEASE EXPLAIN WHY: _____

_____

ADJUSTER: _____ PHONE#:_____

INSURANCE CARRIER:_____ CLAIM #: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

HEALTH HISTORY AND MEDICATIONS CENTER OF ORTHOPEDIC AND REHABILITATION EXCELLENCE	*The Disc Replacement Center, Jordan Valley Medical Center*	***Patient Name:***
	Armen Khachatryan, MD	***Date of Birth:***

General Health Information

We ask that you update this form every **6 months** for accurate medical records.
Please inform your physician of any significant changes.

Date of Appt: _____
Date of Birth: ____/_____/_____ Age: _____ F _____ M_____ Phone: _____
Email Address: _____
Who referred you to our clinic? _____
Names of Doctors who have treated you so far: _____
Chief Complaints: (Medical Problems that brought you here: _____
1. _____
2. _____

MEDICATION ALLERGIES

Please include the reaction you have had (e.g. Rash, hives, swelling, breathing problems, etc.) ***None ☐ Initials:*** _____

MEDICATION NAME	REACTION TO MEDICATION
Circle any additional allergies: Latex / Dyes / Metals / Adhesives / Anesthesia	

CURRENT MEDICATIONS

Please include all meds you are currently taking. Indicate whether "prescribed" or "over the counter." ***None ☐ Initials:*** _____

MEDICATION	DOSE	FREQUENCY	LENGTH OF TIME ON MEDICATION	Prescribed (RX) Over the Counter (OTC)
				☐ Rx ☐ OTC
				☐ Rx ☐ OTC
				☐ Rx ☐ OTC
				☐ Rx ☐ OTC
				☐ Rx ☐ OTC

Preferred Pharmacy: _____ Phone number: _____
All prescriptions will be sent to the pharmacy you indicate on this form. Please notify us if there is a change.

Influenza vaccine in the last 12 months? Y / N **Tetanus booster in last 10 years? Y / N**

HEALTH HISTORY AND MEDICATIONS CENTER OF ORTHOPEDIC AND REHABILITATION EXCELLENCE	*The Disc Replacement Center, Jordan Valley Medical Center* *Armen Khachatryan, MD*	***Patient Name:*** ***Date of Birth:***

Past Hospitalizations / Surgeries: ***None ☐ Initials: _____***	**Approximate Year**	**Surgeon / Hospital**

Other medical problems: _____

FAMILY HISTORY

CONDITION	**RELATIVE** (e.g. father, cousin, etc)	
	Specify which relative	**had which condition or type:**
Diabetes		
Heart Attack		
Cancer (type)		
Stroke		
Bleeding Disorder		
Blood Clot—Please circle (heart/brain/lung/limb)		
Genetic Disorder (please specify)		
Auto-Immune or any other (please specify)		

SOCIAL HISTORY

Marital Status	Single / Married / Partner / Divorced / Widowed / Separated / Child	
Living Arrangements	To prepare for post-surgical care, please indicate living arrangements: Alone / with parents / with spouse / roommates / # of children in the house_____ (age range _____) Other: _____	
Occupation		
Tobacco	Current use: cigarettes / chew / vaporizing products	Packs / tins per day? ____ How Long? _____ If former user: When did you quit? _____
Alcohol	How often?	How much?
Substance Abuse	Current? / Previous History of?	Please indicate substance(s):
Special Needs	Vision / Hearing / Speech / Language / Physical / specify:	
Translator Required?	Language:	

HEALTH HISTORY AND MEDICATIONS CENTER OF ORTHOPEDIC AND REHABILITATION EXCELLENCE	*The Disc Replacement Center, Jordan Valley Medical Center*	***Patient Name:***
	Armen Khachatryan, MD	***Date of Birth:***

REVIEW OF SYSTEMS

Height: _____Feet _____Inches Weight: _____ Lbs
Cardiologist: _____
Are you currently in pain management? ☐ Yes ☐ No

Primary Care Physician: _____
Pacemaker: ☐ Yes ☐ No
Physician Name:_____

Circle all you are currently experiencing or with which you have had significant problems ***None ☐*** ***Initials _____***

Lung	cough / short of breath / (at rest / exertion) / pain when breathing / coughing up blood
Stomach	stomach pain / nausea / vomiting / diarrhea / constipation / blood in stool / black stool
HEENT	changes in hearing/vision / congestion / sore throat / toothache / difficulty swallowing
General	unexplained weight gain or loss/ night sweats / fevers / chills / lumps / bumps
Genitourinary	pain with urination / incontinence / frequent urination / sexual dysfunction
Heart	chest pain (at rest / exertion) / decreased exercise tolerance / palpitations
Nerve	numbness / tingling / headaches / seizures / fainting / imbalance
Muscle	weakness / joint pains / swollen joints / broken bones
Mental	depression / anxiety / confusion / slowed thinking
Skin	rash / blisters / sores/ easy bruising

MEDICAL HISTORY

Please circle conditions you have had or currently have. ***None ☐*** ***Initials: _____***

Cardiovascular	high blood pressure / murmur / heart attack / chest pain—angina / irregular heartbeat / pacemaker / cholesterol / congestive heart failure / valve replacement / peripheral vascular disease		
Blood	pulmonary embolus (PE) / leg or arm clot (DVT) / clotting disorder / bleeding tendency		
Lung	asthma / emphysema / oxygen at home / COPD / shortness of breath / tuberculosis		
Neurologic	neuropathy (numbness) / MS / fibromyalgia / Concussion—Number: _____ Most recent (Date): _____ / seizures / TIA / stroke—Date: _____ Disabilities: _____		
Mental Health	anxiety / depression / attention-deficit disorder / bipolar / confusion / dementia		
Stomach/Bowel	ulcer / hernia / Crohn's / Coeliac / acid reflux (heartburn) / irritable bowel / diverticulosis		
Musculoskeletal	osteoarthritis / rheumatoid arthritis /gout / fractures / joint replacement / specify: Latest bone density DEXA Scan (Year): _____ Result: Normal / Osteopoenia / Osteoporosis		
Diabetes	diet controlled / pills / injections /"pre-diabetic" Latest Hgb A1c: _____	**Sleep Apnea**	CPAP / BiPAP
Cancer	**Type:** **Date:**	**Skin**	eczema / staph infection / MRSA
Thyroid	hypothyroid / hyperthyroid	**Auto-immune**	lupus / celiac / rheumatoid arthritis
Urinary	incontinence / bladder infections / kidney / enlarged prostate / other:	**Liver**	hepatitis / cirrhosis

Patient Questionnaire, SPINE

CURRENT SYMPTOMS

Briefly describe your current complaints: _____
_____

How and when did the problem begin? (gradually or suddenly?):_____
_____

TREATMENT DETAILS

Have you worn braces or corsets? ☐ Yes ☐ No
Physical therapy? ☐ Yes ☐ No
Improvement from therapy? ☐ Yes ☐ No
Prescribed by whom? _____ Where? _____
Visits per week: _____ How many weeks: _____ Date of last visit: _____

Types of therapy?
☐ Active exercise ☐ Home exercise ☐ Pool therapy
☐ Stretching ☐ TENS unit ☐ Traction

Injections?
☐ Epidural steroids ☐ Facet blocks ☐ Other _____
How many times? _____ Where? _____
Did they provide relief? ☐ Yes ☐ No
For how long? _____ Date of last injection: _____

Chiropractic treatments? ☐ Yes ☐ No
How many visits? _____ Where? _____
Did they provide relief? ☐ Yes ☐ No

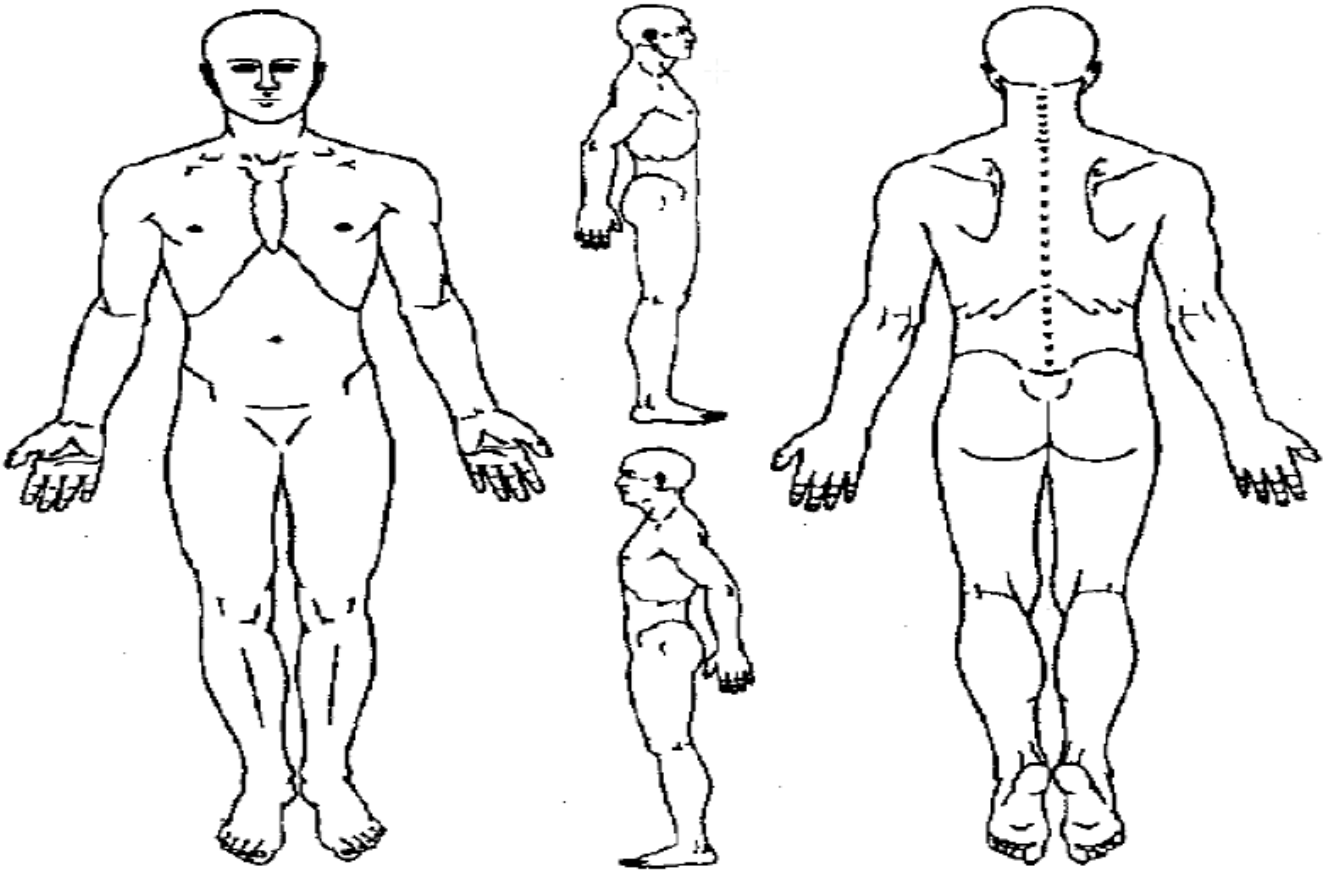
PATIENT SIGNATURE: _____ DATE: _____

If Parent or Legal Guardian, please print name: _____

By signing, I certify that to the best of my knowledge, the information provided is accurate and up to date.

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols shown below. Mark the areas of radiation. Include all affected areas.

Ache ^ ^ ^ / ^ ^ ^ / ^ ^ ^ Numbness o o o / o o o / o o o Pins & Needles = = = / = = = / = = = Stabbing / / / / / / / / /



Which is more troublesome to you? (CIRCLE) Neck/Back Arm/Leg Equal

What is your pain level in your NECK/BACK?

Circle one: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

What is your pain level in your *RIGHT* ARM/LEG?

Circle one: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

What is your pain level in your *LEFT* ARM/LEG?

Circle one: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Possible)