



Dedication Above and Beyond.

Anderson Medical Center

4743 Arapahoe Avenue, Suite 102
Boulder, CO 80303

www.alpinesurgical.net

Phone 303.449.3642 Fax 303.440.7298

PERSONAL INFORMATION:

Today's Date: _____

NAME: Last, First, MI: _____ Male Female Other

Mailing/Billing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Email Address: _____

The office may leave detailed messages on: Home Phone Cell Phone Work Phone Email

Date of Birth: ___/___/___ Age: _____ Social Security Number: ___/___/___

Height: _____ Weight: _____ Blood Pressure (if known): _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single Significant Other Married Legally Separated Divorced Widowed

Spouse's/Other's Name: _____ Work/Cell Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Whom may we thank for referring you to us: _____ Friend Doctor Other

WHAT PHARMACY DO YOU CURRENTLY USE? _____

PHARMACY ADDRESS: _____

PHARMACY PHONE NUMBER: (_____) _____

EMERGENCY CONTACT:

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Relationship: _____

This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released to any person except when you have authorized us to do so.

REASONS FOR THE OFFICE VISIT TODAY (Please list primary symptoms/concerns):

1. _____ Right/Left
2. _____ Right/Left

PERSONAL MEDICAL HISTORY (PLEASE COMPLETELY FILL IN BUBBLES THAT APPLY TO YOUR HISTORY)

Diabetes	<input type="checkbox"/> Yes	GERD	<input type="checkbox"/> Yes
Hyper Thyroidism	<input type="checkbox"/> Yes	Colitis	<input type="checkbox"/> Yes
Hypo Thyroidism	<input type="checkbox"/> Yes	Diverticular Disease	<input type="checkbox"/> Yes
Hyper Parathyroidism	<input type="checkbox"/> Yes	Kidney Stones	<input type="checkbox"/> Yes
Elevated Cholesterol	<input type="checkbox"/> Yes	Kidney Failure	<input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> Yes
Heart Arrhythmia	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> Yes
Heart Failure	<input type="checkbox"/> Yes	COPD/Emphysema	<input type="checkbox"/> Yes
Stroke/TIA	<input type="checkbox"/> Yes	Sleep Apnea	<input type="checkbox"/> Yes
Blood Clot	<input type="checkbox"/> Yes	HIV/AIDS	<input type="checkbox"/> Yes
Pulmonary Embolism	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> Yes	Type of Cancer _____	
High Blood Pressure	<input type="checkbox"/> Yes		
Peptic Ulcer Disease	<input type="checkbox"/> Yes		

Check here if **NONE** of these apply

Other Medical History: _____

SURGICAL HISTORY: (Circle all that apply and include proximate dates of Surgeries) **Check here if no surgical history**

Hernia: Inguinal/Umbilical/Other _____
Dates: _____

Rectum: Hemorrhoids/Fistula/Fissure/Other _____
Dates: _____

Abdomen: Gallbladder/Appendix/Stomach/Intestine/Colon
Other _____
Dates: _____

Breast: Lumpectomy/Mastectomy/Reconstruction/Biopsy
Dates: _____

Head/Neck: Thyroid/Parathyroid/Tonsils/Other _____
Dates: _____

Chest: Heart Bypass/Heart Valve/Heart Catheterization
Lungs /Other _____
Dates: _____

Kidney: Stone/Other _____
Dates: _____

OB /GYN: Hysterectomy/Tubes or Ovaries/C-Section
Dates: _____

Orthopedic: Shoulder/Knee/Hip/Other _____
Dates: _____

Other Surgeries and Dates: _____



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MEDICATIONS: List any medications you are currently taking (including herbals and supplements).

Check here if NONE

Medication	Frequency	Medication	Frequency

ALLERGIES: Please specify if you are allergic to any medicines or medical supplies (including iodine, tape, latex, and shellfish). Check here if NONE

ALLERGY and REACTION (example: Latex-Rash)

ALLERGY and REACTION

SOCIAL HISTORY:

Alcohol Yes No How Often _____

Smoking Yes No How Many Per Day/Week _____

Recreational drugs Yes No Explain What and How Often _____

FAMILY MEDICAL HISTORY: Please indicate if any blood related family members have ever had any of the following

Indicate either Maternal or Paternal side AND Family Member Relationship (i.e. Maternal Grandmother, Paternal Aunt, etc.)

Bleeding problem _____

Heart attack / Stroke _____

Problems with anesthesia _____

Epilepsy/Seizures _____

Diabetes _____

Asthma _____

High blood pressure _____

Cancer (List Type and Family Member) _____

IMAGING: Have you had any imaging for this problem (including MRI, X-Ray, Mammogram, Ultrasound).

Check here if NONE

Type	Date	Location (Facility)

Personal Review of Systems: Have you had any of these recently?

Please Completely Darken ALL Bubbles. Answer ALL Questions.

Constitutional

Weight Change Yes No
 Loss of Appetite Yes No
 Fever Yes No
 Weakness Yes No
 Fatigue Yes No
 Night Sweats Yes No

Dermatology

Rash/Hives Yes No
 Moles/Lumps/Skin Cancer Yes No

Endocrinology

Excessive Sweating Yes No
 Heat/Cold Intolerance Yes No
 Anxiety Yes No
 Jitteriness Yes No
 Hair Change Yes No
 Low Libido Yes No
 Memory Loss Yes No

Neurology

Headache Yes No
 Tingling/Numbness Yes No
 Seizures Yes No
 Dizziness Yes No

Ophthalmology

Diminished Vision Yes No
 Blurring of Vision Yes No

Hematology

Easy Bleeding Yes No
 Bruising Yes No
 Swollen Glands Yes No

Gastroenterology

Difficulty Swallowing Yes No
 Heartburn Yes No
 Abdominal Pain/Cramping Yes No
 Nausea/Vomiting Yes No
 Diarrhea Yes No
 Blood in Stool Yes No

Genitourinary

Changes in Urination Yes No
 Blood in Urine Yes No
 Groin Bulges Yes No
 Testicular Pain Yes No

Psychology

Tension/Stress Yes No
 Sleep Disturbances Yes No
 Suicidal Ideation Yes No
 Eating Disorder Yes No
 Depression Yes No

Musculoskeletal

Joint Pain Yes No
 Joint Swelling Yes No

ENT/Respiratory

Cough/Cold Yes No
 Change in Voice Yes No

Cardiovascular

Chest Pain Yes No
 Palpitations/Murmurs Yes No
 Leg Cramping Yes No
 Leg Pain at Rest Yes No
 Varicose Veins Yes No



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Today's Date: _____

PATIENTS FULL NAME (please print): _____ Date of Birth: _____

GUARANTOR INFORMATION: Person who is responsible for payment.

Name: _____ Employer Name: _____
Address: _____ Employer Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Employer Phone: _____
Date of Birth: _____ Relationship to Patient: _____

Please complete the section below if you are over 18 and wish to allow a friend, spouse, parent, or other family member to discuss medical and/or billing information with our office.

Authorization to Discuss Medical and Billing Information

I, _____, hereby authorize Alpine Surgical to discuss my medical and billing information with the following listed persons.

First and Last name of authorized person: Relationship: (i.e.: mother, son, spouse, friend)
1: _____ 1: _____
2: _____ 2: _____
3: _____ 3: _____
4: _____ 4: _____

Patient Signature: _____

Date: _____



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WHEN REGISTERING, PLEASE PRESENT YOUR PROOF OF INSURANCE, OR PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE

	<u>Primary Insurance</u>	<u>Secondary Insurance</u>	<u>Other</u>
Name of Insurance Co.			
Policyholder			
Policyholder's SS#			
Policyholder's DOB			
Policyholder's Place of Employment			
Relationship to Patient			
Policy/ID Number			
Group/Account Number			
PPO? HMO? Other?			
Co-pay Amount			

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to:

Alpine Surgical, LLC, P.O. Box 18674, Belfast, Maine 04915-4081

A photocopy of this agreement shall be considered effective as the original.

I authorize the release of any information pertinent to my claim and all future claims to my insurance company or adjuster involved in this case and certifies that this insurance information is current and valid. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I agree to pay in full for any services rendered within 30 days of receiving a bill. **All co-pays are due at the time of service.** I understand that failure to supply the office with all of my insurance and/or referral information could result in denial of my insurance claim. If patient does not have insurance coverage, or if the services rendered are not covered by insurance, payment is expected at the time of service.

Check Here If No Health Insurance

Patient Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Alpine Surgical's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Alpine Surgical has the right to change this Notice at any time. I may obtain a current copy by contacting the Practice Privacy Official, or by visiting the Alpine Surgical web site at www.alpinesurgical.net.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Patient or Legal Guardian Signature _____ Relationship _____

For Practice Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason: _____

Signature & printed name of practice representative

Date



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FINANCIAL AGREEMENT FOR ALPINE SURGICAL, LLC

Thank you for choosing Alpine Surgical as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your agreement and understanding of our financial responsibility policy.

I agree that in return for the services provided to me or the patient (if a different person – hereafter the word patient applies to both of us) by Alpine Surgical or providers affiliated with Alpine Surgical, I will pay the account of the patient and/or make financial arrangements satisfactory to Alpine Surgical. Unless the patients' bill is paid by applicable insurance, government programs or other sources, I agree to pay Alpine Surgical's usual and customary charges. I understand and agree that a delinquent account will be subject to interest at the legal rate.

Estimated charges may be given at or before the time of service, but I understand that this is merely an estimate, based upon information that is available at the time and that the actual amount that the patient will be charged for medical services rendered may be different from the estimate of charges for a variety of reasons, including but not limited to, additional procedures, tests or supplies that were not covered in the estimate.

I understand and agree that my insurance and/or the patients' insurance, if any, will be billed for medical services rendered to the patient, and payment from the insurer will be sought by Alpine Surgical before I am required to make payment (with the exception of applicable copayments, deductibles and coinsurances, which I must pay). I understand and agree that I am responsible for and I will pay for medical services rendered to the patient in the event that our insurance does not authorize these services or does not pay for all or any of these services.

If the patient or I am entitled to benefits of any type whatsoever, under any policy of health or liability insurance, or from any other party liable to the patient, that benefit is hereby assigned to Alpine Surgical and/or to the providers rendering services, for application toward the patient's bill. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company. It is understood and agreed, however, that the patient and I are primarily responsible for payment of the patient's bill and that we are obligated to pay and agree to pay for any portion of the bill that is not paid for by insurance or other sources.

I agree that in the event that I need to cancel or reschedule an office appointment, I will provide a 24 hour notice. If unable to provide a 24 hour notice, I will be charged a \$100 no show fee.

I agree that in the event that I need to cancel a surgical or vascular procedure, I will provide a 72 hour notice. If unable to provide a 24 hour notice, I will be charged a \$300 no show fee.

I agree that I am responsible for all costs and expenses associated with or incurred in connection with our enforcement of the Financial Agreement Policy Form, including, but not limited to, charges for returned checks, collection agency fees, court filing fees and attorney's fees.

I have been offered a copy, read, understand and agree to the provisions of this Financial Agreement Policy Form and agree to pay Alpine Surgical promptly all amounts for which I am responsible under this form.

Patient/Authorized Representative

Relationship

Print Name

Date