

**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: \_\_\_\_\_

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. \_\_\_\_\_
2. \_\_\_\_\_

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

Diabetes	<input type="checkbox"/> Yes	GERD	<input type="checkbox"/> Yes
<b>Hyper</b> Thyroidism	<input type="checkbox"/> Yes	Colitis	<input type="checkbox"/> Yes
<b>Hypo</b> Thyroidism	<input type="checkbox"/> Yes	Diverticular Disease	<input type="checkbox"/> Yes
<b>Hyper</b> 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:** Please select or type your past surgeries along with their dates. Check here if no surgical history

**Hernia:**

Dates: \_\_\_\_\_

**Rectum:**

Dates: \_\_\_\_\_

**Abdomen:**

Dates: \_\_\_\_\_

**Breast:**

Dates: \_\_\_\_\_

**Head/Neck:**

Dates: \_\_\_\_\_

**Chest:**

Dates: \_\_\_\_\_

**Kidney:**

Dates: \_\_\_\_\_

**OB /GYN:**

Dates: \_\_\_\_\_

**Orthopedic:**

Dates: \_\_\_\_\_

**Other Surgeries and Dates:** \_\_\_\_\_

\_\_\_\_\_

**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.**

Please check here if none of these apply:

<b>Constitutional</b>		<b>Gastroenterology</b>	
Weight Change	<input type="radio"/> Yes <input type="radio"/> No	Difficulty Swallowing	<input type="radio"/> Yes <input type="radio"/> No
Loss of Appetite	<input type="radio"/> Yes <input type="radio"/> No	Heartburn	<input type="radio"/> Yes <input type="radio"/> No
Fever	<input type="radio"/> Yes <input type="radio"/> No	Abdominal Pain/Cramping	<input type="radio"/> Yes <input type="radio"/> No
Weakness	<input type="radio"/> Yes <input type="radio"/> No	Nausea/Vomiting	<input type="radio"/> Yes <input type="radio"/> No
Fatigue	<input type="radio"/> Yes <input type="radio"/> No	Diarrhea	<input type="radio"/> Yes <input type="radio"/> No
Night Sweats	<input type="radio"/> Yes <input type="radio"/> No	Blood in Stool	<input type="radio"/> Yes <input type="radio"/> No
<b>Dermatology</b>		<b>Genitourinary</b>	
Rash/Hives	<input type="radio"/> Yes <input type="radio"/> No	Changes in Urination	<input type="radio"/> Yes <input type="radio"/> No
Moles/Lumps/Skin Cancer	<input type="radio"/> Yes <input type="radio"/> No	Blood in Urine	<input type="radio"/> Yes <input type="radio"/> No
<b>Endocrinology</b>		Groin Bulges	<input type="radio"/> Yes <input type="radio"/> No
Excessive Sweating	<input type="radio"/> Yes <input type="radio"/> No	Testicular Pain	<input type="radio"/> Yes <input type="radio"/> No
Heat/Cold Intolerance	<input type="radio"/> Yes <input type="radio"/> No	<b>Psychology</b>	
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Tension/Stress	<input type="radio"/> Yes <input type="radio"/> No
Jitteriness	<input type="radio"/> Yes <input type="radio"/> No	Sleep Disturbances	<input type="radio"/> Yes <input type="radio"/> No
Hair Change	<input type="radio"/> Yes <input type="radio"/> No	Suicidal Ideation	<input type="radio"/> Yes <input type="radio"/> No
Low Libido	<input type="radio"/> Yes <input type="radio"/> No	Eating Disorder	<input type="radio"/> Yes <input type="radio"/> No
Memory Loss	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No
<b>Neurology</b>		<b>Musculoskeletal</b>	
Headache	<input type="radio"/> Yes <input type="radio"/> No	Joint Pain	<input type="radio"/> Yes <input type="radio"/> No
Tingling/Numbness	<input type="radio"/> Yes <input type="radio"/> No	Joint Swelling	<input type="radio"/> Yes <input type="radio"/> No
Seizures	<input type="radio"/> Yes <input type="radio"/> No	<b>ENT/Respiratory</b>	
Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Cough/Cold	<input type="radio"/> Yes <input type="radio"/> No
<b>Ophthalmology</b>		Change in Voice	<input type="radio"/> Yes <input type="radio"/> No
Diminished Vision	<input type="radio"/> Yes <input type="radio"/> No	<b>Cardiovascular</b>	
Blurring of Vision	<input type="radio"/> Yes <input type="radio"/> No	Chest Pain	<input type="radio"/> Yes <input type="radio"/> No
<b>Hematology</b>		Palpitations/Murmurs	<input type="radio"/> Yes <input type="radio"/> No
Easy Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Leg Cramping	<input type="radio"/> Yes <input type="radio"/> No
Bruising	<input type="radio"/> Yes <input type="radio"/> No	Leg Pain at Rest	<input type="radio"/> Yes <input type="radio"/> No
Swollen Glands	<input type="radio"/> Yes <input type="radio"/> No	Varicose Veins	<input type="radio"/> Yes <input type="radio"/> No

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:** \_\_\_\_\_



**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.			
Member ID #			
Policyholder's Name			
Policyholder's DOB			
Policyholder's Place of Employment			
Relationship to Patient			
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.

**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](http://www.alpinesurgical.net). My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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



ALPINE  
SURGICAL

*Dedication Above and Beyond.*

**Anderson Medical Center**  
4743 Arapahoe Avenue, Suite 102  
Boulder, CO 80303

[www.alpinesurgical.net](http://www.alpinesurgical.net)  
Phone 303.449.3642 Fax 303.440.7298

**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 72 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 Signature or Authorized Representative**

Relationship

Print Name

Date