ALPINE SURGICAL
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:_____

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: _____

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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	☐ Yes	GERD	☐ Yes
HyperThyroidism	☐ Yes	Colitis	☐ Yes
HypoThyroidism	☐ Yes	Diverticular Disease	☐ Yes
HyperParathyroidism	☐ Yes	Kidney Stones	☐ Yes
Elevated Cholesterol	☐ Yes	Kidney Failure	☐ Yes
Heart Attack	☐ Yes	Seizures	☐ Yes
Heart Arrhythmia	☐ Yes	Asthma	☐ Yes
Heart Failure	☐ Yes	COPD/Emphysema	☐ Yes
Stroke/TIA	☐ Yes	Sleep Apnea	☐ Yes
Blood Clot	☐ Yes	HIV/AIDS	☐ Yes
Pulmonary Embolism	☐ Yes	Cancer	☐ Yes
Anemia	☐ Yes	Type of Cancer_____	
High Blood Pressure	☐ Yes		
Peptic Ulcer Disease	☐ 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:_____

_____

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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 **O** Yes **O** No How Often_____

Smoking **O** Yes **O** No How Many Per Day/Week_____

Recreational drugs **O** Yes **O** 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)

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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: ☐

Constitutional

Weight Change	☐ Yes
Loss of Appetite	☐ Yes
Fever	☐ Yes
Weakness	☐ Yes
Fatigue	☐ Yes
Night Sweats	☐ Yes

Dermatology

Rash/Hives	☐ Yes
Moles/Lumps/Skin Cancer	☐ Yes

Endocrinology

Excessive Sweating	☐ Yes
Heat/Cold Intolerance	☐ Yes
Anxiety	☐ Yes
Jitteriness	☐ Yes
Hair Change	☐ Yes
Low Libido	☐ Yes
Memory Loss	☐ Yes

Neurology

Headache	☐ Yes
Tingling/Numbness	☐ Yes
Seizures	☐ Yes
Dizziness	☐ Yes

Ophthalmology

Diminished Vision	☐ Yes
Blurring of Vision	☐ Yes

Hematology

Easy Bleeding	☐ Yes
Bruising	☐ Yes
Swollen Glands	☐ Yes

Gastroenterology

ifficulty Swallowing	☐ Yes
leartburn	☐ Yes
bdominal Pain/Cramping	☐ Yes
lausea/Vomiting	☐ Yes
iarrhea	☐ Yes
lood in Stool	☐ Yes

Genitourinary

hanges in Urination	☐ Yes
lood in Urine	☐ Yes
roin Bulges	☐ Yes
esticular Pain	☐ Yes

Psychology

ension/Stress	☐ Yes
leep Disturbances	☐ Yes
uicidal Ideation	☐ Yes
ating Disorder	☐ Yes
epression	☐ Yes

Musculoskeletal

oint Pain	☐ Yes
oint Swelling	☐ Yes

ENT/Respiratory

ough/Cold	☐ Yes
hange in Voice	☐ Yes

Cardiovascular

hest Pain	☐ Yes
alpitations/Murmurs	☐ Yes
eg Cramping	☐ Yes
eg Pain at Rest	☐ Yes
aricose Veins	☐ Yes

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Today's Date: _____

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

GUARANTOR INFORMATION: Person who is responsible for payment.

Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Home Phone: _____
Date of Birth: _____

Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip:_____
Employer Phone: _____
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

	Primary Insurance	Secondary Insurance	Other
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.
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

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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 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** _____