

New Patient Registration

Patient Information

Name _____
Last Name First Name Middle Initial

Nickname _____ Soc. Sec. # _____

Address _____
Street City State Zip

Phone # Home: _____ Work: _____ Cellular: _____

Is it ok to leave a detailed message about your medical care? Yes ___ No ___ If yes, circle the # you would prefer we use.

Email _____ May we contact you via email? Yes ___ No ___

Sex ___ M ___ F Age ___ Birth date _____ Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Employer _____ Occupation _____

In case of emergency, who should we notify? _____ Phone _____

Pharmacy _____ Phone _____

How did you find out about our office? _____

Primary Insurance

Name of Insured _____
Last Name First Name Initial

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Additional Insurance

Is Patient covered by additional insurance? ___ Yes ___ No

Name of Insured _____
Last Name First Name Initial

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from Patient) _____

Assignment and Release

I, _____, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Mountain Streams Medical Center, PC** all insurance benefits for services received there. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Responsible Party

Date

Family Physician

Family Physician _____ Phone # _____

Address _____ Fax # _____

Current Medications

Current Medications, Supplements , 1. _____ 4. _____
 Aspirin Products 2. _____ 5. _____
 Or Vitamins 3. _____ 6. _____

Please list any known allergies to medications _____

Please list any other known allergies _____

Health History

Please list any Past Illnesses _____

Please list any Current Illness _____

Please list any Past Surgeries _____

Circle any of the following that applies to you:

- | | | | | |
|--------------------|----------------------|--------------------|------------------------|---------------------|
| Headaches | Breast Lump | Breathing Problems | Hemorrhoids | Family Problems |
| Eye Problems | High Blood Pressure | High Cholesterol | Phlebitis | Sexual Problem |
| Hearing Problems | Arthritis | Heart Trouble | Serious Injury | Sleeping Difficulty |
| Dental/Gum Disease | Gout | Liver Disease | Tuberculosis | Depression |
| Thyroid Disease | Fainting/Convulsions | Stomach Trouble | Rheumatic Fever | Nervousness |
| Diabetes | Abnormal Bleeding | Kidney Disease | Venereal Disease | Stroke |
| Anemia | Hives or Rash | Trouble Urinating | Alcohol /Drug Problems | Other _____ |
| Cancer | Hepatitis | Bowel Trouble | Weight Loss | |

Problems with Varicose Veins or Spider Veins? _____

List Childhood Diseases _____

Hospitalizations: _____

Other Health Issues:

Tobacco use: _____ Age started _____ Amount _____
 Caffeine use: _____ How many times per day? _____
 Alcohol: _____ How many drinks per week _____
 Pregnant? YES NO May be (Circle One)

Family Health History

Family History	Alive/Deceased	Age	Family Health Problems- (cause of death)	Do you have any close relatives with
Father				High Cholesterol
Mother				Heart Trouble
Spouse				Cancer (Breast, Prostate, Colon)
Brothers/Sisters				Diabetes
				High Blood Pressure
				Mental Illness
				Thyroid Disease
Children				Bleeding Trouble or Blood Clots
				Hemorrhoids
				Alcohol / Drug Problems
				Alzheimer's

Patient Name _____

History HEM

Bright red rectal bleeding is a common symptom of hemorrhoids. However, other serious colon and rectal disorders can cause blood in the stool. Please take the time to answer the following questions.

Have you ever seen a physician for rectal bleeding? Yes No if Yes, When? _____ (Yrs) _____ (age)

Have you ever had any of the following diagnostic studies for rectal bleeding?

Sigmoidoscopy? Yes No If Yes, When _____ (Yrs) _____ (age)

Barium enema? Yes No If Yes, When _____ (Yrs) _____ (age)

Colonoscopy? Yes No If Yes, When _____ (Yrs) _____ (age)

Have you ever been advised by a physician to have any of the above tests? Yes No

Have you or anyone in your family ever been diagnosed with colon cancer? Yes No

Have you ever been diagnosed with Crohn's disease, ulcerative colitis, diverticulitis, or and ulcer?

Have you had any of the following Symptoms?

A change in bowel habits? Yes No

A change in the way bowel movements look? Yes No

Blood mixed in bowel movements? Yes No

Hemorrhoid History

Pain associated with hemorrhoids? Yes No

Pain upon standing Pain upon sitting Pain upon bending

Pain upon stooping Pain upon lifting Pain with other

Bleeding associated with hemorrhoids? Yes No Frequency Constant Intermittent

Itching associated with hemorrhoids? Yes No Frequency Constant Intermittent

Protrusion of tissue? Yes No

Please note any additional symptoms: _____

Please list all therapies, remedies and treatments (doctor prescribed or over-the-counter) you have tried. Please be as detailed as possible:

Patient Name _____



Our Policies:

- If you are covered by health insurance, you are strongly encouraged to consult with your health insurer to determine accurate information about your financial responsibility for a particular health care service provided by a health care provider at this office. If you are not covered by health insurance, you are strongly encouraged to contact our billing office at 303.469.7300/ 719.634.6700 to discuss payment options prior to receiving a health care price that may not reflect the actual amount of your financial responsibility.
- As a complimentary service to you, our office will do its best to assist all of our patients in determining their insurance benefits to estimate out of pocket expenses as accurately as possible with the information we are provided by the patient and his/her insurance company. Because of the nature of insurance we cannot promise that what we quote as an estimate of out of pocket expense will be exact or final.
- The final balance cannot be ascertained with your insurance company until the final billing to the insurance company has been billed and processed and our office has received the explanation of benefits from your insurance company.
- We are happy to help in any way we can with questions or concerns you may have about payment and benefits, but it is ultimately the patient's and/or policy holder's full responsibility for payment of their account. If for any reason your insurance company declines payment of services provided at this office you will be held responsible for payment in full. We may ask for your help and support in obtaining payment from your insurance and/or submitting any information (letters, medical history, etc.) that will help them determine proper coverage.
- Refunds: It will take approximately 60 to 90 days upon the completion of your care at our clinic to finalize your account. This 60 to 90 day period is required by your insurance company to assure the processing of your claim(s)._____ (initials)
- Collections: If your account and/or policy holder's account is turned over to collections for any reason we will assess a \$25.00 fee plus any administrative, collection agency commissions or legal costs incurred during this process. If an account balance remains unpaid for 90 days it will automatically be sent to a collection agency._____ (initials)
- Missed appointments: Without 24 hours notice on any canceled or rescheduled appointments the appointment will be considered a "no show." On your 3rd and/or any subsequent "no show" appointment your account will be charged \$35. _____ (initials)
- Friday Missed Appointments: Occasionally we are in office Fridays and appointments will be offered. Any "no show" without a 24 hr notice will immediately incur a \$75 "Friday no show" fee._____ (initials)
- Payment: The entire cost of your visit, according to the quote given by your insurance company, will be due immediately following your appointment._____ (initials)
- Insurance Quote: Payment in full is due at the time of service. We may need to send a bill to collect any remaining amount if the insurance quote isn't completely accurate. A maximum of two (2) complimentary invoices will be mailed. Any invoices after this will incur a \$5 statement fee._____ (initials)

This agreement supersedes any previous agreement. I have read and understand this agreement.

Guarantor/Patient Sign

Date

Office Representative

Date