

4743 Arapahoe Avenue Suite 102 Boulder CO 80303

www.boulderbreastcenter.com Phone 303.449.3642 Fax 303.440.7298

PERSONAL INFORMATION:	То	day's Date:	
NAME: Last, First, MI:		☐ Male ☐	Female
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 P	hone Cell Phone	Work P	hone Email
Date of Birth:/ Age:	Social Security Nu	mber:	//
Height: Weight: BI	ood Pressure (if known):		
Employer:	Occupation:		
Employer Address:	City:	State:	Zip:
Marital Status: O Single O Significant Other O Marrie Spouse's/Other's Name:			
Primary Care Physician <u>:</u>	Phone Num	ber <u>:</u>	
Whom may we thank for referring you to us:		☐ Friend ☐	Doctor
WHAT PHARMACY DO YOU CURRENTLY USE?PHARMACY ADDRESS:			
PHARMACY PHONE NUMBER: ()	_		
EMERGENCY CONTACT:			
Name:	Home Phone:		
Address:	Work Phone:		
City: State: Zip:	Cell Phone:		
Relationshin:			

Boulder Breast Center AT ALPINE SURGICAL Comprehensive Breast Care

Boulder Breast Center

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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.

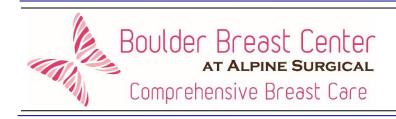
REASONS FOR THE OFFICE	VISIT TODAY (Please list primary s	ymptoms/concerns):						
1			Right/Left					
			Right/Left					
	ORY (PLEASE COMPLETELY FILL IN							
Diabetes	O Yes	GERD	O Yes					
Hyper Thyroidism	O Yes	Colitis	O Yes					
Hypo Thyroidism	O Yes	Diverticular Disease	O Yes					
Hyper Parathyroidism	O Yes	Kidney Stones	O Yes					
Elevated Cholesterol	O Yes	Kidney Failure	O Yes					
Heart Attack	O Yes	Seizures	O Yes					
Heart Arrhythmia	O Yes	Asthma	O Yes					
Heart Failure	O Yes	COPD/Emphysema	O Yes					
Stroke/TIA	O Yes	Sleep Apnea	O Yes					
Blood Clot	O Yes	HIV/AIDS	O Yes					
Pulmonary Embolism	O Yes	Cancer	O Yes					
Anemia	O Yes	Type of Cancer						
High Blood Pressure	O Yes							
Peptic Ulcer Disease	O Yes	Check here if NONE of the	ese apply					
Other Medical History:								
SURGICAL HISTORY: (Circle	e all that apply and include proximate	e dates of Surgeries) Check her	re if no surgical history					
Hernia: Inguinal/Umbilical/C	Other	Chest: Heart Bypass/Heart	Valve/Heart Catheterization					
Dates: Rectum: Hemorrhoids/Fistula/Fissure/Other Dates:		Lungs /Other Dates: Kidney: Stone/Other						
					Abdomen: Gallbladder/Appendix/Stomach/Intestine/Colon Other Dates: Breast: Lumpectomy/Mastectomy/Reconstruction/Biopsy		Dates:	
							OB /GYN: Hysterectomy/Tubes or Ovaries/C-Section Dates: Orthopedic: Shoulder/Knee/Hip/Other	
Dates:								
, ,	roid/Tonsils/Other	<u> </u>						
Dates:								



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Medication		Frequency	Medication	Frequency
LERGIES: Please spe	ecify if you are aller	rgic to any medicine	s or medical supplies (includ	ding iodine, tape, latex, and
•	k here if NONE	,		
ALLERGY and	REACTION (examp	le: Latex-Rash)	ALLERGY and REAC	TION
			<u> </u>	
OCIAL HISTORY:				
lcohol	O Yes O No I	How Often		
moking	O Yes O No	How Many Per Day/	Week	
C		•	ow Oftenfamily members have ever ha	
AMILY MEDICAL HIS	STORY: Please indicat al or Paternal side AN	te if any blood related	family members have ever ha	
AMILY MEDICAL HIS dicate either Materna	STORY: Please indicat al or Paternal side AN	te if any blood related	family members have ever ha	d any of the following
AMILY MEDICAL HIS dicate either Materna eeding problem eart attack / Stroke	STORY: Please indicat al or Paternal side AN	te if any blood related	family members have ever ha	d any of the following
AMILY MEDICAL HIS dicate either Materna eeding problem eart attack / Stroke roblems with anesthes	STORY: Please indicat al or Paternal side AN	te if any blood related	family members have ever ha	d any of the following
AMILY MEDICAL HIS dicate either Maternal eeding problem eart attack / Stroke roblems with anesthes pilepsy/Seizures	STORY: Please indicat al or Paternal side AN	te if any blood related	family members have ever ha	d any of the following
AMILY MEDICAL HIS dicate either Materna deeding problem eart attack / Stroke roblems with anesthes pilepsy/Seizures	STORY: Please indicat al or Paternal side AN	te if any blood related	family members have ever ha	d any of the following
AMILY MEDICAL HIS dicate either Maternal eeding problem eart attack / Stroke roblems with anesthes pilepsy/Seizures iabetes	STORY: Please indicat al or Paternal side AN sia	te if any blood related	family members have ever ha	d any of the following
AMILY MEDICAL HIS dicate either Materna deeding problem eart attack / Stroke roblems with anesthes pilepsy/Seizures iabetes sthma igh blood pressure	STORY: Please indicat al or Paternal side AN	te if any blood related	family members have ever ha	d any of the following ndmother, Paternal Aunt, etc.
AMILY MEDICAL HIS dicate either Materna deeding problem eart attack / Stroke roblems with anesthes pilepsy/Seizures iabetes isthma igh blood pressure ancer (List Type and Fa	STORY: Please indicat al or Paternal side AN sia amily Member)	te if any blood related	family members have ever ha	d any of the following ndmother, Paternal Aunt, etc.
AMILY MEDICAL HIS dicate either Materna deeding problem eart attack / Stroke roblems with anesthes pilepsy/Seizures iabetes isthma igh blood pressure ancer (List Type and Fa	STORY: Please indicat al or Paternal side AN sia amily Member)	te if any blood related	family members have ever ha	d any of the following ndmother, Paternal Aunt, etc.
AMILY MEDICAL HIS dicate either Materna eeding problem eart attack / Stroke roblems with anesthes pilepsy/Seizures iabetes igh blood pressure ancer (List Type and Fa	STORY: Please indicat al or Paternal side AN sia amily Member)	te if any blood related ND Family Member Re	family members have ever ha	d any of the following ndmother, Paternal Aunt, etc. am, Ultrasound).



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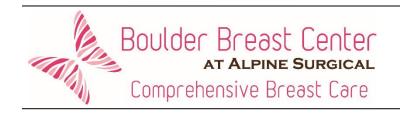
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Personal Review of Systems: Have you had any of these recently?

Please Completely Darken ALL Bubbles. Answer ALL Questions.

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



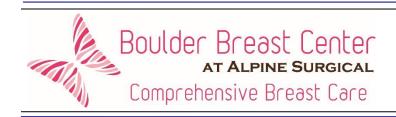
Patient Signature: _____

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Today's Date: _____ PATIENTS FULL NAME (please print):______ Date of Birth:_____ **GUARANTOR INFORMATION:** Person who is responsible for payment. Employer Name: _____ Name: _____ Employer Address:______ Address: City: State: Zip: City: _____ State: ____ Zip:_____ Employer Phone:_____ Home 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. Relationship: (i.e.: mother, son, spouse, friend) First and Last name of authorized person:



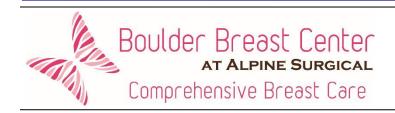
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WHEN REGISTERING, PLEASE PRESENT YOUR PROOF OF INSURANCE, OR PAYMENT IN FULL IS EXPECTED AT THE TIME **OF SERVICE**

	Primary Insurance	Secondary Insurance	<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 Insu			4004
·	rgical, LLC, P.O. Box 18674,	Belfast, Maine 04915	-4081
A photocopy of this agreement shal	I be considered effective as the o	original.	
office with all of my insurance and/insurance coverage, or if the service Check Here If No Health Ins	es rendered are not covered by ir		•
Patient Signature:		D	ate:
	VLEDGEMENT OF RECEIPT OF NO		
I have been given a copy of Alpine Surgi understand that Alpine Surgical has the Official, or by visiting the Alpine Surgica My signature below acknowledges that	right to change this Notice at any till web site at www.alpinesurgical.ne	me. I may obtain a current copy by o	
Patient or Legal Guardian Signature		Relationship	
	Use Only: Complete this section if e is unable or unwilling to sign acknown.		e.
	 ce representative	 	te



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FINANCIAL AGHREEMENT FOR ALPINE SURGICAL, LLC

Print Name

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

Date