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

www.boulderbreastcenter.com/
Phone 303.449.3642 Fax 303.440.7299

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 message on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Date of Birth Age Social Security number

Height Weight Blood Pressure

Employer Occupation

Employer address City State Zip

Marital status ☐ Single ☐ Significant Other ☐ Married ☐ Legally Separated ☐ Divorces ☐ Widowed

Spouse's/Other's Name Work/Cell Number

Primary Care Physician Phone Number

Fax Number

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

WHAT PHARMACY DO YOU USE

PHARMACY ADDRESS

PHARMACY PHONE NUMBER

EMERGENCY CONTACT

Name

Relationship

Address City State Zip

Home Phone

Work Phone

Cell Phone

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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. _____ ☐ Right ☐ Left
2. _____ ☐ Right ☐ Left

PERSONAL MEDICAL HISTORY (FILL IN BUBBLES THAT APPLY TO YOUR HISTORY) Check here if NONE apply ☐

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

Other Medical History

SURGICAL HISTORY: (Circle all that apply and include approximate dates of Surgeries) Check here if NO surgical history ☐

Hernia (Inguinal/Umbilical/Other)
Date(s)

Chest (Heart Bypass/Heart Valve/Heart Catherization/Lung/Other)
Date(s)

Rectum (Hemorrhoid/Fistula/Fissure/Other)
Date(s)

Kidney (Stone/Other)
Date(s)

Abdomen (Gallbladder/Appendix/ Stomach/ Intestine/Colon/Other)
Date(s)

OB/GYN (Hysterectomy/Tubes or Ovaries/C-Section/Other)
Date(s)

Breast (Lumpectomy/Mastectomy/ Reconstruction/Biopsy/Other)
Date(s)

Orthopedic (Shoulder/Knee/Hip/Other)
Date(s)

Head/Neck (Thyroid/Parathyroid/Tonsils/Other)
Date(s)

Other Surgeries
Date(s)

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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 _____
Problem with anesthesia _____
Epilepsy/Seizures _____
Diabetes _____
Asthma _____
High Blood Pressure _____
Cancer (List Type and Family Member) _____
Other _____

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.

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
Swollen Glands	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

Change in Urination	Yes	No
Blood in Urine	Yes	No
Groin Bulge	Yes	No
Testicular Pain	Yes	No

Psychology

Tension/Stress	Yes	No
Sleep Disturbance	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 _____

Guarantor Information Person Responsible for payment

Name:	Employer Name:
Address:	Employer Address:
City: State: Zip:	City: State: Zip:
Home Phone:	Employer Phone Number:
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
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.			
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.

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 _____ 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: _____

Staff Signature _____ Date _____
Signature & printed name of practice representative

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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 or Legal Guardian Signature | Relationship

Print Name | Date