New Patient Registration

Patient Information

Name ____ Soc. Sec. # ________________________
Last Name First Name Initial

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 ______________________

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. # ______________________

Address (if different form Patient)____
Street City State Zip

Insured Employed by ____ Occupation __________________________
Bus. Address ____ Bus. Phone _________________________

Insurance Co ____
Name Address Phone #

Member No ______________________ Group # _____________________ Subscriber # ________________________

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) ____
Street City State Zip

Insured Employed by ____ Occupation ___________________________

Bus. Address ____ Bus. Phone ________________________

Insurance Co ____
Name Address Phone #

Member No _____________________ Group # ______________________ Subscriber # ________________________

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

Patient Name____

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 Maybe (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____

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:____

____

____

____

____

Our Policy:

- 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 service from a health care provider at this office since posted health care prices may not reflect the actual amount of your financial responsibility.
- 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 but due to the nature of insurance we cannot promise that the provided quote 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.
- The entire cost of your visit, according to the quote given by your insurance company, which you understand is only an estimate, will be due right after your visit.________
- 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).________
- Since full payment is due at time of service, we may need to send a bill to collect any remaining balance if the quote isn't fully accurate. A maximum of two (2) complimentary invoices will be mailed. Any following invoices will incur a $5 statement fee.________
- 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.__________
- Without 24 hours of 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. ________

I have read and understand this agreement.

________________________________		________________________________	
Guarantor/Patient Sign	Date	Office Representative	Date