# 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 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**_____

## 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 Policy:

If you are covered by health insurance, you are strongly encouraged to consult with our 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 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 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.

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*)**

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*)**

The entire cost of your visit, according to the quote given by your insurance company, will be due immediately following your appointment._____**(*initials*)**

Since 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*)**

**I have read and understand this agreement.**

| | | | |
|---|---|---|---|
| **Guarantor/Patient Sign** | **Date** | **Office Representative** | **Date** |