Mountain View Surgical Associates

PATIENT NUMBER:		DATE:			
PATIENT LAST NAME	FIRST NAME	MIDDLE INIT	SSN		SUFFIX
ADDRESS 1		CITY	STATE		ZIP
ALTERNATE ADDRESS 2		CITY	STATE		ZIP
HOME TEL #	WORK TEL #	EXT	CELL #	SEX	AGE
BIRTHDATE	EMPLOYER		E-MAIL ADDRESS		

CURRENT VISIT

USUAL PROVIDER	REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN		
MARITAL STATUS	EMPLOYMENT STATUS ☐Full ☐ Part ☐ Retired	STUDENT STATUS ☐Full ☐ Part	HIPAA SIGNED (Date)	REL TO GUARANTOR
RACE	ETHNICITY	LANGUAGE	INTERPRETER NEEDED	PHARMACY

GUARANTOR INFORMATION

GUARANTOR LAST NAME	FIRST NAME	MIDDLE INIT	SSN		SUFFIX
ADDRESS 1		CITY	STATE		ZIP
ALTERNATE ADDRESS 2		CITY	STATE		ZIP
HOME TEL #	WORK TEL #	EXT	CELL #	SEX	EMERGENCY ☐Y ☐N
BIRTHDATE	EMPLOYER		E-MAIL ADDRESS		

INSURANCE INFORMATION

1	CARRIER NAME	CARRIER ADDRESS			
	CERTIFICATE ID #	GROUP NAME	CLAIM/GROUP NO.	CARRIER PHONE #	COVERAGE TYPE
	SUBSCRIBER NAME	SUBSCRIBER D.O.B.	SUBSCRIBER SSN	RELATIONSHIP TO PATIENT	
2	CARRIER NAME	CARRIER ADDRESS			
	CERTIFICATE ID #	GROUP NAME	CLAIM/GROUP NO.	CARRIER PHONE #	COVERAGE TYPE
	SUBSCRIBER NAME	SUBSCRIBER D.O.B.	SUBSCRIBER SSN	RELATIONSHIP TO PATIENT	
3	CARRIER NAME	CARRIER ADDRESS			
	CERTIFICATE ID #	GROUP NAME	CLAIM/GROUP NO.	CARRIER PHONE #	COVERAGE TYPE
	SUBSCRIBER NAME	SUBSCRIBER D.O.B.	SUBSCRIBER SSN	RELATIONSHIP TO PATIENT	

EMERGENCY CONTACT INFORMATION

1	EMERGENCY CONTACT #1			SUFFIX
	HOME PHONE #	WORK PHONE #	CELL PHONE #	RELATIONSHIP TO PATIENT
2	EMERGENCY CONTACT #1			SUFFIX
	HOME PHONE #	WORK PHONE #	CELL PHONE #	RELATIONSHIP TO PATIENT

Mountain View Surgical Associates

Notice of Receipt of Privacy Practices

Patient Name
Date of Birth:

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer at 303-805-1855.

Uses and Disclosures of Health Information

For Treatment: We may use medical information about you to provide you with medical treatment or services. This may include electronic access of your medication history information. This information could include insurance benefits, eligibility and formulary information, prescribing provider and pharmacy, medication history, as well as prescription refill and renewal information. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you now or in the future.

We may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health,

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed and payment may be collected from you, an insurance company or third party.

For Healthcare Operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use tour PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to insure anonymity.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name: _____ **Phone:** _____

Patient Signature: _____ **Date:** _____

Legal Representative: _____ **Date:** _____
Relationship

Mountain View Surgical Associates

Authorizations for Release of Health Information

Please answer the following three questions regarding the release and disclosure of your medical and billing information. Please return the completed form (signed and dated) to the front desk.

1. Do we, Mountain View Surgical Associates, have your permission to release your medical information to ALL <u>your</u> healthcare providers and insurance companies? ☐ Yes ☐ No

2. Do we, Mountain View Surgical Associates, have your permission to obtain your medical information from ALL of your healthcare providers and insurance companies? ☐ Yes ☐ No

2. Please list all family member(s)/guardian(s) that may access your <u>medical records and/or financial and billing information.</u> Please List ALL:

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Mountain View Surgical Associates, Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Mountain View Surgical Associates actually receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Printed Patient Name _____ Patient's Date of Birth _____

Signature of Patient _____ Date _____

Signature of Client/Personal Representative _____ Relationship to Patient _____

Please note, this form expires one year after signed. You will be asked to complete this form annually.

Mountain View Surgical Associates

Patient History Questionnaire

Please help us be as efficient as possible with your first visit to our program. This health history questionnaire **must** be completed prior to your appointment. Should you need assistance with answers to any of the questions asked, feel free to contact our office and we will be happy to help you. You may fax the completed form to our office prior to your appointment at (303) 805-1855 Health history questionnaires that are incomplete or forgotten at the time of your appointment and/or arriving late for your appointment may result in rescheduling a portion of or your entire appointment.

Today's Date:		Referring Doctor:			
How are you recognized by your insurance?					
Last Name:		First Name:		Middle Init:	
Date of Birth (MM/DD/YYYY):		Gender:			
Please note preferred if different from above:					

Medical Decision Making – Please mark if you have...			
An Advanced Directive?	☐ Yes ☐ No	A Living Will?	☐ Yes ☐ No
Medical Power of Attorney?	☐ Yes ☐ No	Name/Relationship/Phone:	
Are Enrolled in a Hospice?	☐ Yes ☐ No	Name and Phone of Hospice:	
Resident of Care Facility?	☐ Yes ☐ No	Name and Phone of Care Facility:	

Please list any doctors that you are currently seeing as a patient:			
	Doctors Name	Type of Doctor	Condition Being Treated
Referring Physician			
Primary Care Provider			
Oncologist			
Cardiologist			
Other			
Other			

Local Pharmacy:				Mail Order Pharmacy:			
Name:				Name:			
Address:				Address:			
Phone:		Fax:		Phone:		Fax:	

Reason For Visit: What is the main reason you are seeing the doctor today?

Patient Name:

Mountain View Surgical Associates

Patient History Questionnaire

Past Medical History: *Do you Personally have any of the following problems? If yes, please explain.*

	Yes	No	Date of Onset	Comments	Check if Resolved
AIDS or HIV	☐	☐		Date of Testing:	☐
Atherosclerosis/artery disease	☐	☐			☐
Asthma	☐	☐			☐
Bleeding Tendency	☐	☐			☐
Cancer	☐	☐		Type:	☐
Chemical Dependency	☐	☐		Type:	☐
Chest Pain	☐	☐			☐
COPD	☐	☐			☐
Diabetes	☐	☐			☐
Insulin Dependent (Type I)	☐	☐			☐
Non Insulin Dep (Type II)	☐	☐			☐
Emphysema	☐	☐			☐
Heart Disease/Heart Attack	☐	☐			☐
Indicate type(s)					☐
Hepatitis	☐	☐		Type:	☐
High Blood Pressure	☐	☐			☐
Kidney Disease	☐	☐			☐
Mitral Valve Prolapse	☐	☐			☐
Previous Blood Transfusion	☐	☐			☐
Stroke	☐	☐			☐
Tuberculosis	☐	☐		Date of Testing:	☐
Valley Fever	☐	☐			☐
Vascular Disease	☐	☐			☐
Other:	☐	☐			☐
Other:	☐	☐			
Other:	☐	☐			

Allergies:: List allergens and associated reactions (e.g. Hives, Rash, Nausea…)

☐ No Known Drug Allergies			☐ No Know Food Allergies		
Aspirin	☐ Yes	☐ No	Latex	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Adhesive tape	☐ Yes	☐ No
Morphine	☐ Yes	☐ No	Other drug, food, environmental allergens:	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No	If Yes, What?		
Sulfa	☐ Yes	☐ No	If Yes, What?		
Coumadin / Warfarin/Plavix	☐ Yes	☐ No	Shellfish or IVP dye (used in angiograms)?	☐ Yes	☐ No
Other:			Other:		
Other:			Other:		

Patient Name: **Date Printed:**

Mountain View Surgical Associates

Patient History Questionnaire

Family History: *Check if your blood relatives have had any of the following, If Yes, please specify.*

☐ Family Medical History Unknown/Adopted

	Mother	Father
Age		
Health State (Good, Fair, Poor…)		
Age of Death		
Cancer – Type:	☐	☐
Diabetes		
Type I	☐	☐
Type II	☐	☐
Heart Disease-Type:	☐	☐
High Blood Pressure	☐	☐
Kidney Diseases	☐	☐
Prostate Diseases	☐	☐
Other:_____	☐	☐
Other: _____	☐	☐

Social History:

Tobacco Use: ☐ Never ☐ Former Smoker – When did you stop? _____ ☐ Smoker – Packs per day? _____

Alcohol Use: ☐ Never ☐ Occasionally ☐ Moderate ☐ Daily Type & drinks/week _____

Recreational Drug/Non-prescribed narcotics: ☐ Never ☐ Type & Frequency _____

Caffeine: ☐ Never ☐ Coffee, # cups _____Day/Week ☐ Tea, # cups _____Day/Week
☐ Soda, # cups _____Day/Week ☐ Chocolate

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Occupation:_____

Medications: *Please list any medications including aspirin, vitamins, over –the-counter, or herbal medications.*

Medication Name	Dose	Frequency & Reason	Medication Name	Dose	Frequency & Reaso
Vitamins/Herbal Supplements			Other:		
Type(s):					
Anti-Inflammatories?					
i.e. Advil/Aleve/Ibuprofen					
Coumadin / Warfarin/ Plavix					

Pregnancy/Birth History (FEMALE Only)

Last Menstrual Cycle Date _____ Are you currently/possibly pregnant ☐ Yes ☐ No

	Year	Sex	Complications, if any	Year	Sex	Complications, if any
Pregnancies (Births,						
Miscarriages, Abortions)						

Patient Name: **DOB:** **Date Printed:**

Mountain View Surgical Associates

Patient History Questionnaire

Past Surgical History

History of anesthesia problems? ☐Y ☐N If Yes, list type and reactions:_____

Year	Procedure	Surgeon/Location	Year	Procedure	Surgeon/Location
	Abdomen Surgery (any kind)			Hernia	
	Appendectomy			Hysterectomy	
	Bowel Resection			Pancreatic	
	Breast			Thyroid	
	Cardiac			Vascular	
	Cholecystectomy (Gallbladder Surgery)			Vasectomy	
	Colorectal			Other:	
	C-Section			Other:	

Diagnostic Studies (CT, X-ray, Ultrasound, MRI, etc.)

Year	Type	Location	Year	Type	Location
	Angiogram			MRI	
	Colonoscopy			PET Scan	
	CT Scan			Ultrasound	
	EGD			X-Ray	
	Mammogram (Female)				

Review of Systems: *Please tell us about current symptoms you are experiencing.*

* General		*Cardiovascular (cont'd)		*Musculoskeletal (cont'd)	
Chills	☐Y ☐N	Chest Pain	☐Y ☐N	Neck Pain	☐Y ☐N
Fatigue	☐Y ☐N	Varicose Veins	☐Y ☐N	*** Neurological**	
Fever	☐Y ☐N	*Varicose Veins Section	☐Y ☐N	Dizziness	☐Y ☐N
Tiredness	☐Y ☐N	Leg Pain	☐Y ☐N	Numbness	☐Y ☐N
Headache	☐Y ☐N	Leg Ulcers	☐Y ☐N	Tremor	☐Y ☐N
*** Skin**		Previous Therapy	☐Y ☐N	Tingling	☐Y ☐N
Rash	☐Y ☐N	Type and Leg:	☐Y ☐N	*** Psychiatric**	
Boils	☐Y ☐N	*** Gastrointestinal**		Anxiety	☐Y ☐N
Persistent Itch	☐Y ☐N	Abdominal Pain	☐Y ☐N	Depression	☐Y ☐N
***Head & Neck (HEENT)**		Bloody Stool	☐Y ☐N	Trouble Falling Asleep	☐Y ☐N
Blurred Vision	☐Y ☐N	Constipation	☐Y ☐N	Personality Changes	☐Y ☐N
Double Vision	☐Y ☐N	Diarrhea	☐Y ☐N	*** Endocrine**	
Ear Infection	☐Y ☐N	Hemorrhoids	☐Y ☐N	Cold Intolerance	☐Y ☐N
Sore Throat	☐Y ☐N	Heartburn	☐Y ☐N	Excessive Thirst	☐Y ☐N
Sinus Problems	☐Y ☐N	Indigestion	☐Y ☐N	Heat Intolerance	☐Y ☐N
*** Respiratory**		Nausea	☐Y ☐N	Thyroid Problems	☐Y ☐N
Wheezing	☐Y ☐N	Rectal Bleeding	☐Y ☐N	*** Hematology**	
Frequent Cough	☐Y ☐N	Vomiting	☐Y ☐N	Abnormal Bleeding	☐Y ☐N
Hay Fever	☐Y ☐N	*** Genitourinary**		Easy Bruising	☐Y ☐N
Shortness of Breath	☐Y ☐N	Blood in Urine	☐Y ☐N	***Varicose Veins**	
*** Breast**		Flank Pain	☐Y ☐N	**Have you used...**	
Breast Mass	☐Y ☐N	Painful Urination	☐Y ☐N	Prescription Stockings	☐Y ☐N
Breast Pain	☐Y ☐N	***Musculoskeletal**		How Long Worn?	☐Y ☐N
Nipple Discharge	☐Y ☐N	Back Pain	☐Y ☐N	Exercise	☐Y ☐N
		Joint Pain	☐Y ☐N	Type:	

Patient Name: **DOB:** **Date Printed:**

Mountain View Surgical Associates

Welcome to Mountain View Surgical Associates! We realize that your time is important and that many forms have been presented to you. This particular form will help us to assess your risk for breast cancer.

How old were you when you began menstruating (began having your period)? _____

How many times have you been pregnant? _____

How many children did you give birth to? _____

How old were you when your first child was born? _____

Did you breast feed any of your children? Yes _____ No _____
How many? _____
For how long? _____

Have you used oral contraceptives, Depo-Provera, or a hormone secreting IUD for birth control? _____

Which one (s) _____

How old were you when you went through menopause? _____

Did you have a hysterectomy or uterine ablation therapy? _____

Were your ovaries removed? _____

Did you take hormone replacement therapy? Yes _____ No _____
For how long? _____

Do you have a family history of:
Breast Cancer: Yes _____ No _____
Who? _____

Age of diagnosis (if known)? _____

Ovarian Cancer: Yes _____ No _____
Who? _____

Age of diagnosis (if known)? _____

Colon Cancer: Yes _____ No _____
Who? _____

Age of diagnosis (if known)? _____

Any other cancer? Yes _____ No _____
Type of cancer? _____ Who? _____

Age of diagnosis (if known)? _____

Prior to this, have you ever had a breast biopsy before? Yes _____ No _____
When? _____

Diagnosis? _____

If you have any additional information you feel is pertinent please describe? _____

_____