

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 <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Retired	STUDENT STATUS <input type="checkbox"/> Full <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> 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 your 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: _____
Relationship

Date: _____

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 your healthcare providers and insurance companies? No Yes

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

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

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:	
<i>Please note preferred if different from above:</i>			

Medical Decision Making – Please mark if you have...			
An Advanced Directive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	A Living Will?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Power of Attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name/Relationship/Phone:
Are Enrolled in a Hospice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name and Phone of Hospice:
Resident of Care Facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:		Phone:	
Fax:		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	<input type="checkbox"/>	<input type="checkbox"/>		Date of Testing:	<input type="checkbox"/>
Atherosclerosis/artery disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Type:	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>		Type:	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Insulin Dependent (Type I)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Non Insulin Dep (Type II)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Heart Disease/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Indicate type(s)					<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Type:	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Previous Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		Date of Testing:	<input type="checkbox"/>
Valley Fever	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

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

<input type="checkbox"/> No Known Drug Allergies		<input type="checkbox"/> No Know Food Allergies	
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adhesive tape	<input type="checkbox"/> Yes <input type="checkbox"/> No
Morphine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other drug, food, environmental allergens:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, What?	
Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, What?	
Coumadin / Warfarin/Plavix	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shellfish or IVP dye (used in angiograms)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		
Type I	<input type="checkbox"/>	<input type="checkbox"/>
Type II	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease-Type:	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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

Patient Name: _____

DOB: _____

Date Printed: _____