Ivinson MEMORIAL HOSPITAL
an affiliate of UNIVERSITY OF COLORADO HEALTH
MEDICAL GROUP

New Patient Information

Thank you for allowing Ivinson Medical Group to participate in your healthcare. In order to develop a professional working relationship, we ask that you please review and understand the following protocol. Your initials by each of the statements below and signature at the end of the document indicates you agree to abide by the following guidelines:

_____ Patients without insurance are responsible for payment, or payment arrangements, in full AT the Time of Service.

_____ Our office makes reminder calls the business day prior to your appointment, as a courtesy to our patients. Failure to cancel appointments the business day prior, may subject patient to a no-show fee or discharge from practice.

_____ Failing to attend a scheduled appointment may result in a $50 no-show fee.

_____ If you would like copies of our IMH Notice of Privacy Practices and/or Patient Rights and Responsibilities, pamphlets are available at the clinic.

_____ Photo ID and insurance card(s) will be required at check-in.

_____ Please notify the receptionist immediately if you have any changes to address, phone number or insurance.

_____ Specific subscriber information for the policy holder will be required: name, date of birth, social security number and employer. Failure to provide correct information can result in billing errors. Ivinson Memorial Hospital and Ivinson Medical Group are not responsible for errors associated.

_____I hereby authorize for payment of medical benefits, when a claim is filed by the office, to be made to Ivinson Memorial Hospital and any assisting clinicians, for the service/s rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ Failure to comply with clinic protocol may result in clinic discharge.

_____ _____

Signature of Patient or Legal Guardian Date

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PATIENT INFORMATION:

Last Name:_____ First Name:_____ M.I.:_____

Other names used: _____

Address:_____ City:_____, State:_____

Zip Code:_____

Phone: (_____) _____ Preferred Contact Method: ☐ **Email** ☐ **Phone** ☐ **Text** ☐ **Mail**

May we leave messages on your answering machine regarding your care? Yes***** ☐ No ☐

*****Please understand that if we leave messages, it will be your responsibility to initiate a return call to discuss your care with us.

Social Security Number:_____ Date of Birth:_____ Age: _____

Sex: M ☐ F ☐ Marital Status: _____ (**S**ingle, **M**arried, **D**ivorced, **W**idowed)

Employer Name/City/State: _____

Employer Phone: (____) _____

Email Address: _____

I wish to be set up for IMH's Patient Portal using the Email address above: Yes☐ No☐

INSURANCE INFORMATION: (***Does NOT*** need to be filled out if you presented your card to receptionist)

Primary Insurance: _____ Policy Holder's Name:_____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security Number: _____

Policy Number: _____ Group Number: _____ Co-pay Amt: _____

Secondary Insurance: _____ Policy Number:_____

Primary Care Provider Name:_____City:_____State:_____

Oxygen Company (if applicable) ___

Home Health Agency (if applicable) _____

Name_____

EMERGENCY CONTACT:

Last Name: _____ First Name: _____

Address: _____

Phone Number: _____ Relationship: _____

RELEASE:

Please list people with whom we can discuss your care and leave messages:

1. _____ Phone: _____

2. _____ Phone: _____

Do you have an Advance Health Care Directive? Yes ☐ No* ☐ *Please let your provider know if you are interested in obtaining information about Advance Health Care Directives.

Patients Are Responsible for Payment in Full AT the Time of Service. Our office makes reminder calls 24 hours before appointments, and will charge a $50 no-show fee if two or more appointments are missed without notifying our office. Your signature below indicates that you understand and accept this policy.

I hereby authorize for payment of medical benefits, when a claim is filed by the office, to be made to Ivinson Memorial Hospital and any assisting clinicians, for the service/s rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I also acknowledge that I have reviewed the copies of the **IMH Notice of Privacy Practices and the IMH Patient Rights and Responsibilities**.

_____ _____

Patient / Representative Signature **Date**

Name_____

Current Medications	Dosage	How Often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications do you take occasionally (1-2 times/week)? _____
Do you take any alternative or herbal medications? No ☐ Yes, List _____

PHARMACY:
Local _____Mail Order_____

ALLERGIES
Do you have any allergies to medications (please list medication and reaction):_____
_____
_____
Do you have other allergies (food or environmental)? _____

Please place a mark next to any of the following medical conditions or surgeries that apply to you:

MEDICAL PROBLEMS:

☐ Seizures
☐ Atrial Fibrillation
☐ Coronary Artery Disease (CAD)`
☐ Congestive Heart Failure (CHF)
☐ High Blood Pressure
☐ High cholesterol
☐ History of cardiac arrest, heart attack, if yes, date _____
☐ History of stroke, how many _____ date of last stroke _____
☐ Asthma, if so, have you been hospitalized overnight for asthma? Yes ☐ No ☐
☐ COPD/Emphysema, if yes, do you use supplemental Oxygen? Yes ☐ No ☐
☐ History of Obstructive Sleep Apnea, if yes, do you use CPAP ☐ BiPAP ☐
☐ History of difficulties with anesthesia – describe _____
☐ History of GERD (gastro esophageal reflux disease)
☐ History of stomach ulcers
☐ History of inflammatory bowel disease (Crohn's disease or Ulcerative Colitis)
☐ History of liver problems (hepatitis, cirrhosis, etc.) _____
☐ History of kidney problems (renal failure, or insufficiency)
☐ History of mental health disorders (type) _____
☐ History of suicide attempt, how many _____, date of last attempt _____
☐ History of Diabetes, if yes, do you use oral medications, insulin or both?_____
☐ History of thyroid problems (type) _____
☐ History of a blood clotting disorder
☐ Medical problems/ overnight hospital stays other than childbirth or planned surgeries?
☐ Other problems not listed above _____

Name_____

SURGICAL HISTORY (please indicate the year each surgery was completed)

☐	Appendectomy	_____
☐	Bone or joint surgery (which bone/joint) _____	_____
☐	EGD	_____
☐	Colonoscopy	_____
☐	Gallbladder surgery	_____
☐	Hernia repair	_____
☐	Hysterectomy	_____
☐	Cancer (What area of the body): _____	_____
☐	Skin cancer removal (What area of the body): _____	_____
☐	Tonsils/Adenoids removed	_____
☐	Tubal Ligation - Do you still have your ovaries? Yes☐ No ☐	_____
☐	Vasectomy	_____
☐	Any other surgeries? (please list): _____	_____

FAMILY HISTORY

Is your father alive? Y ☐ N ☐ Age? _____ If deceased, age at time of death, reason for death

_____

Did he have any other medical problems? _____

Is your mother alive? Y ☐ or N ☐ Age?_____ If deceased, age at time of death, reason for death

_____

Did she have any other medical problems? _____

How many siblings do you have? _____ Do they have any medical problems?_____

Do any other diseases run in your family? If so, list relationship of family member and type of disease:

_____

SOCIAL HISTORY

Do you smoke cigarettes/e-cigarettes? Y ☐ N ☐

How much? _____ How many years? _____ Former smokers, when did you quit? _____

Do you use chewing tobacco, snuff or other forms of tobacco? Y* ☐ N ☐
*Type_____

Do you use recreational drugs (Marijuana,etc), Y* ☐ N ☐

*Please list_____

Do you use Alcohol? Y* ☐ N ☐

*How many glasses of wine/ liquor/mixed drinks/beers per week?_____

Name_____

IMMUNIZATION HISTORY

Date Received

_____Tdap (Tetanus, diphtheria and pertussis-whooping cough)
_____Tetanus
_____Pneumonia Vaccine (PCV 23)
_____Prevnar (PCV 13)
_____Zostavax (Shingles)
_____Influenza (Flu)
_____Hepatitis (A/B)
_____Meningococcal (Meningitis)

HEALTH MAINTENANCE

Date Received

_____Bone Density (DEXA Scan)
_____Mammogram (female)
_____Pap Smear (female)
_____Digital Rectal Examination (Prostate Screen) (male)
_____PSA (male)

SYSTEM REVIEW

Please place a mark next to each symptom that applies to you currently:

___Poor Appetite
___Weight Gain
___Weight Loss
___Fever, Chills
___Excess Sweating
___Fatigue
___Temperature Intolerance
___ Ear Pain
___Ear Drainage
___Ear Blockage
___Ringing in Ears
___Hearing Loss
___Dizziness
___ Fainting
___Seasonal Allergies
___Cough
___Shortness of Breath
___Rash on Skin
___Hair/Nail problems
___Itching
___Headaches
___Increased Thirst
___Increased Urine Volume
___Bloody Sputum
___Wheezing
___Chest Pains
___Heart Palpitations/Skipping

___Nervousness
___Depression
___Trouble Sleeping
___Voice Change
___Dental or Gum Issues
___Throat Discomfort
___Heartburn/Indigestion
___Difficulty Swallowing
___Special Food Intolerance
___Abdominal Pain
___Vomiting
___Vomiting Blood
___Nasal Congestion
___Nasal Drainage
___Sore Throat
___Hoarseness
___Lumps and/or Nodules
___Snoring
___Nosebleed
___Swollen Glands
___Bruise or Bleed easily
___Muscle or Joint pain
___Numbness/Weakness/Paralysis
___Faulty Memory
___Eye Pain or Redness
___Visual Disturbances