ROARING FORK SURGICAL ASSOCIATES, PROF. LLC

BRAD NICHOL, M.D. **RANDALL E. ROSS, M.D.**

PATIENT INFORMATION

Last Name _____ First Name _____ MI ____ DOB _____ Sex F M

Mailing/Physical Address _____ City _____ State _____ Zip _____

Home Phone# _____ Cell Phone # _____ SS# _____

Email Address _____ Race _____ Ethnicity _____

Marital Status S M W D Spouse's Name _____ Preferred Pharmacy _____

Name of Your Employer _____ Phone # _____

INCASE OF EMERGENCY, NOTIFY _____ **PHONE #** _____

PRIMARY INSURANCE HOLDER

Last Name _____ First Name _____ DOB _____ Relationship _____

MEDICAL INFORMATION

Physician Who Referred You To Us (Or Your Primary Doctor): Dr.(first)_____(last)_____

Is this a WORKMAN'S COMP case? NO YES If yes, please fill out additional paperwork.

Do you have a living will? YES NO

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION

I, the undersigned, knowing the patient is suffering from a condition requiring health care, diagnosis, and medical treatment, hereby voluntarily agree to such diagnostic procedures and health care services that may be administered to or performed on the patient under the instructions of the physician, his assistants or assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, or Insurance Company.

FINANCIAL POLICY

I, the undersigned, assume full responsibility for all medical charges incurred as a patient with Roaring Fork Surgical Associates, Prof. L.L.C. Payment in full is due at the time the patient receives services or supplies unless specific arrangements are made in advance. If this account remains unpaid for over 60 days, it may be turned over to an attorney/collection agency for collection. In which event, the undersigned agrees to be responsible for all costs incurred for this account including reasonable attorney/collection fees with accrued interest at the rate of 18% per annum.

I authorize and request the insurance company to pay directly to Roaring Fork Surgical Associates, Prof. L.L.C. the amount due in my pending claim for Basic Medical, Major Medical, and/or surgical treatment of services by reason of such treatment or services rendered to the patient.

I have read and understand the authorization for treatment/release of information and financial policy and agree to all the terms stated therein until such time as I deliver written notice to the contrary to Roaring Fork Surgical Associates, Prof. L.L.C.

_____

Patient Signature Date

_____

Patient's Legal Guardian's Signature (if patient is under the age of 18 years old) Date

ROARING FORK SURGICAL ASSOCIATES PHYSICAL EXAMINATION RECORD

DR. BRAD NICHOL, M.D. DR. RANDALL ROSS, M.D.

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Age _____ Number of Children _____

Present Complaint:

Medication: *(Please list all medications And supplements or attach a list.)*

_____
_____
_____
_____

Are you currently taking Aspirin or blood thinners?

Yes No

If so, list medication and last dosage:

_____

Operations: *Please list the dates they were preformed.*

Appendix	NO	YES	_____
Colon	NO	YES	_____
Gallbladder	NO	YES	_____
Hernia	NO	YES	_____
Spine	NO	YES	_____
Joint Replacement	NO	YES	_____
Breast	NO	YES	_____
Uterus	NO	YES	_____
Ovaries	NO	YES	_____

Other_____

Diagnosed Difficulties: *Do you now or have you in the past had any of the following? If yes, please explain.*

Heart Attack	NO	YES	_____
High Blood Pressure	NO	YES	_____
Asthma	NO	YES	_____
Lung Problems	NO	YES	_____
Blood Problems	NO	YES	_____
Diabetes	NO	YES	_____
Cancer	NO	YES	_____

Do you currently have a pacemaker? NO YES

Are you fully vaccinated for COVID-19? NO YES

Please list any other medical problems:

Personal History:

Have you lost weight in the past year? *If yes, how much?*

No Yes _____

Allergies: *Are you allergic to any of the following?*

Penicillin	NO	YES	Other_____
Sulfa	NO	YES	
Latex	NO	YES	
Iodine	NO	YES	

Allergies to **Any Other Drug or Medicine?** Please explain:

_____

Do you smoke? NO YES

Have you smoked previously? NO YES

Cigarettes NO YES Marijuana NO YES

Other _____

How Often? _____

Packs per day _____ Years Smoking _____

Do you drink alcoholic beverages? NO YES

Beer NO YES **Wine** NO YES

Other_____

Screenings: *Have you had any of the following? If yes, when?*

Mammogram	NO	YES	_____
PAP Smear	NO	YES	_____
Colonoscopy	NO	YES	_____

Family History: *Has any **blood relative** ever had:* *If yes, who?*

Cancer, Luekemia	NO	YES	_____
Diabetes	NO	YES	_____
Heart Trouble	NO	YES	_____
Heart Attack	NO	YES	_____
High Blood Pressure	NO	YES	_____
Bleeding Disorder	NO	YES	_____

	Living	Deceased	Age of Death	Cause of Death
Father				
Mother				
Brother				
Sister				

Family History: Unknown Adopted

_____ _____

Patient Signature **Date**

OFFICE USE ONLY: **Weight:**_____ **Height:**_____ **Temp:**_____ **BP:**_____/_____ **HR:**_____ **Ox:**_____

Acknowledgment of Receipt of Notice of Privacy Practice

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed that **Roaring Fork Surgical Associates Prof. LLC.** has a *Notice of Privacy Practices* form for me to review prior to signing this consent, if I wish. I understand that I may request a copy of the *Notice of Privacy Practices.*

_____

Print Name of Patient

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a **minor** or an adult who us **unable** to sign this form)

_____

Relationship Patient Representative to Patient