PREMIER SURGEONS

7780 SOUTH BROADWAY, SUITE 250
LITTLETON, CO 80122
PHONE: (303) 795-3375 FAX: (303) 795-0621

PATIENT INFORMATION

DATE: _____
NAME: _____ EMAIL: _____
ADDRESS_____
CITY_____ STATE _____ ZIP_____
HOME PHONE_____ CELL PHONE_____
BIRTH DATE_____ AGE_____ SEX_____ MARITAL STATUS ☐Single ☐Married ☐Other
PATIENT'S SOCIAL SECURITY #_____ OCCUPATION_____
PATIENT'S EMPLOYER_____WORK PHONE _____

EMERGENCY CONTACT INFORMATION

NAME_____ RELATIONSHIP_____
ADDRESS _____ PHONE _____
PRIMARY CARE PHYSICIAN_____ PHONE _____
WHO REFERRED YOU TO US?_____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR PAYMENT_____ ☐ SELF ☐SPOUSE ☐ OTHER
ADDRESS (IF DIFFERENT THAN PATIENT'S) _____
INSURED'S EMPLOYER_____WORK PHONE # _____
INSURED'S SOCIAL SECURITY # _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ IS A REFERRAL REQUIRED? ☐ YES ☐NO
INSURED'S NAME_____ REFERRAL AUTH # _____
ID#_____ GROUP # _____
WORKER'S COMPENSATION: ☐YES ☐NO AUTO ACCIDENT ☐ YES ☐NO IF YES, DATE OF INJURY_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I HEREBY AUTHORIZE PAYMENT BE MADE DIRECTLY TO MY PHYSICIAN FOR MEDICAL AND/OR SURGICAL BENEFITS, IF ANY. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL. I ALSO HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY MY INSURANCE.

SIGNATURE_____DATE_____
☐ PATIENT OR ☐ GUARDIAN RELATIONSHIP TO PATIENT _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE PREMIER SURGEONS TO RELEASE INFORMATION REQUESTED BY MY INSURANCE COMPANY OR WORKER'S COMPENSATION CARRIER. I ALSO AUTHORIZE PREMIER SURGEONS TO RELEASE INFORMATION TO ANY HOSPITAL OR PHYSICIAN I MAY BE REFERRED TO BY THIS OFFICE.

SIGNATURE _____DATE_____
☐PATIENT OR ☐ GUARDIAN RELATIONSHIP TO PATIENT _____

PREMIER SURGEONS

Date: _____

Name: _____ Date of Birth: _____

1. Reason for visit today:
   _____
2. Height: _____ Weight: _____
3. Medical History (list major illnesses, if any): ☐ None

_____
_____
_____
_____ ☐ I have a Pacemaker.

4. Surgical History: ☐ None

_____
_____
_____

5. Medications (including over-the-counter): ☐ I take NO medications, vitamins, or supplements.

_____	_____
_____	_____
_____	_____

6. Allergies: ☐ I have NO allergies. ☐ I have a LATEX ALLERGY. ☐ I have an IODINE ALLERGY.

DRUG ALLERGY	REACTION
_____	_____
_____	_____
_____	_____

7. Do you smoke? ☐ YES ☐ NO If yes, how much per day? _____
8. Do you consume alcohol? ☐ YES ☐ NO If yes, how much per day? _____
9. Do you take any illicit drugs? ☐ YES ☐ NO If yes, how often?
   _____
10. Do you exercise? ☐ NEVER ☐ OCCASIONALLY ☐ OTHER: _____
11. Family history of cancer, cardiac disease, diabetes:

_____
_____
_____

I have reviewed the above history.
Physician's Initials: _____
Date: _____

PREMIER SURGEONS

Medical History / Review of Systems

Date: _____

Name: _____ Date of Birth: _____

NEUROLOGIC / HEAD, EYES, EARS, NOSE, THROAT	NO	YES	DIGESTIVE (Stomach/Bowel)	NO	YES
Numbness/Tingling			Abdominal Pain		
Loss of strength			Nausea/Vomiting		
Stroke (CVA/TIA)			Constipation/Diarrhea		
Headaches - type_____			Colitis		
MS			Diverticulitis		
Ear problems			Hiatal hernia		
Eye problems			Reflux esophagitis		
Nose/Sinus problems			Irritable bowel		
Throat problems			Ulcers		
MUSCULOSKELETAL / SKIN	NO	YES	Pancreatitis		
Back/Neck/Joint problems			Rectal bleeding or pain		
Loss of sensation			Change in bowel habits		
Rash			Cirrhosis		
Arthritis - type_____			Jaundice		
Fractures			Hemorrhoids		
Osteoporosis			Gallstones		
Joint replacement			GENITOURINARY / GYN	NO	YES
ENDOCRINE	NO	YES	Kidney problems		
Tired/Sluggish			Bladder infections		
Excessive thirst			Kidney failure		
Diabetes			Prostate problems		
Thyroid problems			Uterine problems		
RESPIRATORY	NO	YES	Ovarian problems		
Wheezing			BLOOD / IMMUNE SYSTEM	NO	YES
Shortness of breath			Swollen lymph glands		
Productive/bloody cough			Anemia		
Bronchitis			DVT/Phlebitis/Clots		
Pneumonia			Lupus		
Pulmonary embolism			CANCER	NO	YES
Tuberculosis			Type		
CARDIAC	NO	YES	Treatment		
Heart murmur			Location		
Chest pain/Angina			PSYCHOLOGICAL / EMOTIONAL	NO	YES
Palpitations			Nervousness		
Congestive heart failure			Anxiety		
Heart attack			Depression		
High blood pressure			Other		
Pacemaker			CONSTITUTIONAL	NO	YES
Artificial heart valve			Fever		
Rheumatic fever			Chills		
COMMUNICABLE DISEASES	NO	YES	Weight loss		
Malaria			Night sweats		
AIDS/HIV			Weight gain		
Hepatitis A B or C					
Sexually transmitted disease					
Tuberculosis					
BREAST	NO	YES			
Nipple discharge					
Lump					
Prior surgery					

I have reviewed the above history.

Physician's Initials: _____

Date: _____

PREMIER SURGEONS

FINANCIAL POLICY

Thank you for choosing Premier Surgeons. We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company; we are not a party to that contract. Not all services are covered by all contracts.

We participate and accept from most major payers, which means covered charges, will be paid directly to us. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received remittance from your insurance carrier.

If your plan requires a referral from your Primary Care Physician, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to lack of referral you will be responsible for the charges.

We accept cash or checks, and for your convenience, Visa, MasterCard or Discover. We encourage you to promptly contact our billing company, Aspen Medical Management, for assistance in the management of your account. They can be reached at (719) 576-4171.

PATIENT FINANCIAL AGREEMENT

I hereby authorize Premier Surgeons to apply for benefits on my behalf for all my services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any information necessary to my insurance company to determine benefits for services rendered. I request that payment of authorized benefits be made payable directly to Premier Surgeons on my behalf.
I understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

_____ _____

Signature of Patient, Policy Holder or Legal Guardian Date

Printed Name: _____