DWIGHT ROBERTSON MD
PIKES PEAK INTERNAL MEDICINE

1855 Austin Bluffs Parkway, Suite A Colorado Springs, CO 80918
(719) 535-8900 Fax (719) 535-8986

PATIENT REGISTRATION

Patient Last Name_____ First Name_____ Initial_____

Address_____ Apt/Unit_____ City_____ State____ Zip_____

Birthdate_____/_____/_____ Male____ Female____

Email _____ Telephone: Home_____ Cell_____

Emergency contact_____ Telephone_____ Relationship_____

Does anyone have Medical Power of Attorney for you? Name_____ Telephone_____

Primary Insurance_____ ID#_____ Group_____

Policy holder name if different from patient_____ Birthdate____/____/____ Relation to patient_____

Secondary Insurance_____ ID#_____ Group_____

Policy holder name if different from patient_____ Birthdate____/____/____ Relation to patient_____

Preferred Pharmacy_____ Address_____Telephone_____

I have read, understand, and completed the information on this form to the best of my ability and certify that I am the patient or duly authorized representative to furnish the information requested. I am financially responsible for all charges per Pikes Peak Internal Medicine Associates LLC Financial Agreement. I agree that a photocopy of this agreement will be as valid as the original.

Patient Signature_____ Printed Name_____ Date____/____/____

rev. 12/10/10

Pikes Peak Internal Medicine Associates, L.L.C.

HEALTH QUESTIONNAIRE

NAME_____ **Date of Birth:**___-___-____ **Today's Date:**___-___-____

PAST MEDICAL HISTORY:

Diagnosis	(circle)	When?	Diagnosis	(circle)	When?	Diagnosis	(circle)	When?
Heart Disease.....	NO YES	_____	High Cholesterol....	NO YES	_____	Anemia.....	NO YES	_____
Hypertension.....	NO YES	_____	Diabetes.....	NO YES	_____	Blood Clot.....	NO YES	_____
Stroke.....	NO YES	_____	Thyroid Disease.....	NO YES	_____	Venereal Disease..	NO YES	_____
Cancer of _____	NO YES	_____	Hepatitis.....	NO YES	_____	Tuberculosis.....	NO YES	_____
Pneumonia.....	NO YES	_____	Liver Disease.....	NO YES	_____	Measles.....	NO YES	_____
Asthma.....	NO YES	_____	Kidney Disease.....	NO YES	_____	Chicken Pox.....	NO YES	_____
Emphysema.....	NO YES	_____	Peptic Ulcer.....	NO YES	_____	Rheumatic Fever....	NO YES	_____

HOSPITALIZATIONS, SERIOUS ILLNESS:

Illness	Year	&/or Age

SURGERIES:

Type of Surgery	Year	&/or Age

MEDICATIONS: (List all current)

Name:	Dose:	Frequency:	Name:	Dose:	Frequency:
1. _____	_____	_____X daily	6. _____	_____	_____X daily
2. _____	_____	_____X daily	7. _____	_____	_____X daily
3. _____	_____	_____X daily	8. _____	_____	_____X daily
4. _____	_____	_____X daily	9. _____	_____	_____X daily
5. _____	_____	_____X daily	10. _____	_____	_____X daily

ALLERGIES:(Medication & Food)

Name:	Reaction:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SOCIAL HISTORY: (circle)

Marital Status: S M Sep D W **# Children**_____

Occupation: _____ **# Hrs/Wk**_____

Do You Smoke? NO YES # Pack/Day_____ #Yrs_____

Former Smoker? NO YES When did you quit?_____

Alcohol? NO YES Kind?_____ Amt_____ per_____

Drug Use? NO YES Kind?_____ Amt_____ per_____

Caffeine? NO YES Kind?_____ Amt_____ per_____

Regular Exercise? NO YES Kind?_____ Amt_____ per_____

Do You Have An Advance Directive/Living Will ? NO YES

PREVENTIVE HEALTH / SCREENING:

Vaccine: Year		Mo/Yr
Influenza	_____	Last Physical Exam? ___/___
Pneumonia	_____	Last Lab Work? ___/___
Tetanus	_____	PAP/Prostate Exam? ___/___
Other	_____	Mammogram? ___/___
		Colonoscopy? ___/___
		Bone Density? ___/___
		Chest XRay? ___/___
		EKG? ___/___
		Treadmill/Stress Test ___/___

FAMILY HISTORY:

	If Living: Age:	Health:	If Deceased: Age at death & cause:	
Father.....	_____	_____	_____	_____
Mother.....	_____	_____	_____	_____
Brother/Sister.....	_____	_____	_____	_____
Brother/Sister.....	_____	_____	_____	_____
Brother/Sister.....	_____	_____	_____	_____
Son/Daughter.....	_____	_____	_____	_____
Son/Daughter.....	_____	_____	_____	_____
Son/Daughter.....	_____	_____	_____	_____

Has any blood relative ever had:

	(circle)	Which One?
High Blood Pressure	NO YES	_____
Heart Disease	NO YES	_____
Stroke	NO YES	_____
High Cholesterol	NO YES	_____
Diabetes	NO YES	_____
Cancer (what type?) _____	NO YES	_____
Thyroid Problems	NO YES	_____
Asthma	NO YES	_____

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SYSTEM REVIEW

NAME_____ **Date of Birth:**____-____-____ **Today's Date:**____-____-____

GENERAL	(circle)	
Do you eat a well balanced diet?	NO	YES
Approx Wt. now _____ 1 yr ago _____	NO	YES
Maximum Weight _____		
Do you have excessive or unexplained fatigue?	NO	YES
EAR, NOSE, THROAT		
Glasses or contacts	NO	YES
Poor vision or vision loss	NO	YES
Cataracts	NO	YES
Glaucoma	NO	YES
Have you seen an eye doctor? (when_____)	NO	YES
Allergies or Hay fever	NO	YES
Septal deviation or Nasal polyps	NO	YES
Frequent nosebleeds	NO	YES
Sinus infections	NO	YES
Ear infections	NO	YES
Hearing loss	NO	YES
Ringing in ears	NO	YES
Persistent, unexplained hoarseness	NO	YES
NECK		
Injury, pain, stiffness	NO	YES
Swollen glands	NO	YES
RESPIRATORY		
Shortness of breath	NO	YES
Wheezing or asthma	NO	YES
Chronic cough	NO	YES
Coughing up blood	NO	YES
Night sweats	NO	YES
How many blocks can you walk without having to stop to catch your breath? _____		
Have you had a positive skin test for Tuberculosis? (if so, when_____)	NO	YES
CARDIOVASCULAR		
Chest pain or angina	NO	YES
Rapid, hard, or skipped beats	NO	YES
Heart murmer	NO	YES
Shortness of breath when lying flat	NO	YES
Ankles often badly swollen	NO	YES
Leg muscle pain on walking, relieved by rest	NO	YES
GASTROINTESTINAL		
Decreased appetite or weight loss	NO	YES
Frequent heartburn or indigestion	NO	YES
Intolerance to spicy foods, coffee or alcohol	NO	YES
Intolerance to milk products	NO	YES
Intolerance to fatty foods	NO	YES
Hiatal hernia	NO	YES
Pancreatitis	NO	YES
Gallbladder trouble	NO	YES
Frequent vomiting	NO	YES
Frequent diarrhea	NO	YES
Chronic constipation	NO	YES
Frequent abdominal pain	NO	YES
Bloody or black bowel movements	NO	YES
Hemorrhoids	NO	YES

GENITOURINARY	(circle)	
Loss of urine when you cough or sneeze	NO	YES
Kidney or bladder infection (circle)	NO	YES
Burning or frequent urination	NO	YES
Feeling you must go immediately	NO	YES
Do you have to get up at night to urinate? #____	NO	YES
Blood in urine	NO	YES
Kidney stones	NO	YES
Difficulty starting urination	NO	YES
Decrease in strength of stream	NO	YES
Penile discharge	NO	YES
MUSCULOSKELETAL		
Significant joint pain (where?)_____	NO	YES
Low back pain	NO	YES
Muscle tenderness or weakness	NO	YES
Fractures (where?)_____	NO	YES
DERMATOLOGIC		
Rash	NO	YES
Skin cancers	NO	YES
New or changing skin lesions	NO	YES
NEUROLOGIC/PSYCHIATRIC		
Numbness (where?)_____	NO	YES
Paralysis (where?)_____	NO	YES
Fainting or passing out	NO	YES
Frequent dizziness or loss of balance	NO	YES
Memory loss	NO	YES
Migraine or frequent headaches	NO	YES
Are you often depressed?	NO	YES
Are you often anxious?	NO	YES
Have you even been under psychiatric care?	NO	YES
HEMATOLOGIC		
Have you ever been diagnosed as anemic?	NO	YES
Have you ever been told not to give blood?	NO	YES
Excessive bleeding or bruising	NO	YES
ENDOCRINE		
Excessive thirst	NO	YES
Excessive urination	NO	YES
Intolerance to slightly warm rooms	NO	YES
Intolerance to slightly cold rooms	NO	YES
Change in texture of hair or skin	NO	YES
Decreased libido	NO	YES
GYNECOLOGICAL (women only)		
Breast mass or lump or nipple discharge	NO	YES
Family history of breast cancer	NO	YES
Abnormal PAP smear	NO	YES
Pelvic inflammatory disease	NO	YES
Sexually transmitted disease	NO	YES
Pain with intercourse	NO	YES
Irregular menstrual periods	NO	YES
Painful menstrual periods	NO	YES
Menopausal Age?_____	NO	YES
Number of pregnancies____ C sections____		
Deliveries____ Miscarriages____ Abortions____		
Did someone help you to fill this out?	NO	YES

Patient Signature:_____ **Reviewing Physician:**_____

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FINANCIAL AGREEMENT

Welcome to our office! Thank you for choosing us for your health care. We want to make you aware of our policies and procedures regarding payment and insurance billing.

Patients with insurance agree to provide us with a copy of their current insurance card and demographic information. As a courtesy we will bill your insurance company for your services. We attempt to identify in advance what services will be covered, and what portion of your bill will be your responsibility as deductible or co-insurance. Please note that any balances due not covered by your insurance are expected to be paid at the time of service. As it is often not possible to predict the extent of payment from insurances, you may have an additional balance due after insurance has processed your claim. Please refer carefully to the Explanation of Benefits sent to you by your insurance company for information on how your claim was processed.

It is important to verify with your insurance that your coverage is in effect. You agree to promptly notify us of any change in your insurance coverage, and of any changes in your personal information including address, telephone number, email address, or responsible party. You agree that you are responsible for all of the bills you incur regardless of whether you have insurance, and if insurance payment is denied for any reason, you will be responsible for prompt payment of the unpaid charges. Uninsured patients will be seen on a cash pay basis and are expected to pay their bill at the time of service.

You agree that any unpaid balances are due within 30 days of becoming due. You also agree to pay a $70 no-show fee for any missed appointment not cancelled in advance.

As a part of our services, we may draw blood or obtain specimens for outside testing. We will provide your insurance information to any third party to whom we submit specimens, and they will bill your insurance but you may be billed by them for any unpaid charges. If copies of your records are requested by other health care facilities, these may be provided directly to them without charge with a signed consent for release of information. If records are requested for personal use, attorneys, insurance underwriting or other non-provider use we will charge a reasonable fee.

Commercial Insurance We are contracted with many commercial insurers and will submit claims on your behalf. Some plans, however, restrict patient's access to a smaller network of contracted providers or in some instances a single provider. It is your responsibility to ensure that our services are covered by your insurer. You will be responsible for any copayment or deductibles at the time of service.

Medicare We accept Medicare Part B and most Medicare Advantage plans. If you have Medicare and a supplemental insurance plan, Medicare will automatically submit claims to your secondary plan for payment of the deductible (if covered) and copayment portion of your bill. **You are responsible for notifying Medicare of your secondary insurance information.** Please note that some Medicare secondary insurers do not cover the annual Medicare deductible or have a patient copay which you will be responsible for.

Assignment of Benefits and Authorization to Release Information. I hereby assign any insurance benefits to which I am entitled to Pikes Peak Internal Medicine Associates LLC. I authorize and direct my insurance carrier(s) to issue payment directly to Pikes Peak Internal Medicine Associates LLC for services provided to me or my dependents. I authorize Pikes Peak Internal Medicine Associates to release any information necessary to my insurance plan(s) concerning my medical care to process claims and a photocopy of my signature can be used to process claims indefinitely unless revoked in writing. A photocopy of this assignment is to be deemed valid as the original.

Signature_____ **Printed Name**_____ **Date**____/____/____