

# SURGICAL ASSOCIATES OF WESTERN COLORADO

\_\_\_\_\_  
Name of patient (please print)

\_\_\_\_\_  
Date

## Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received Surgical Associates of Western Colorado's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient or patient representative

\_\_\_\_\_  
Date

## Documentation of Good Faith Efforts

To obtain patient's acknowledgement that they received provider's  
Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient)

The patient presented to the office on \_\_\_\_\_ and was provided with a copy of Surgical Associates of Western Colorado's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because \_\_\_\_\_  
\_\_\_\_\_
- Acknowledgement will be made at the next available opportunity.
- Other reason (described below):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Employee Completing Form

\_\_\_\_\_  
Date

**SURGICAL ASSOCIATES OF WESTERN COLORADO, PC**

NAME – FIRST MIDDLE LAST FAMILY DOCTOR SOCIAL SEC # REFERRING DOCTOR

MAILING ADDRESS CITY STATE ZIP HOME PHONE

STREET ADDRESS CITY STATE ZIP CELL PHONE

EMPLOYER OCCUPATION HOW LONG WORK PHONE

DATE OF BIRTH AGE MARITAL STATUS GENDER RELIGION  
S M D W SEP M F

REASON FOR VISIT: PRIOR TREATMENT FOR THIS? WHEN?

HOW DID YOU HEAR ABOUT OUR PRACTICE? DOCTOR/FRIEND/RELATIVE/PHONE BOOK/OTHER?  
NAME: \_\_\_\_\_.

ANY RECENT X-RAYS, CT SCANS, MRI, ULTRASOUND, LABWORK? \_\_\_\_\_  
WHERE: \_\_\_\_\_

HAS ANY FAMILY MEMBER BEEN TREATED IN OUR PRACTICE? YES / NO  
IF SO, WHO? \_\_\_\_\_

EMERGENCY CONTACT:  
NAME HOME PHONE WORK PHONE CELL PHONE

IF UNDER 18 – RESPONSIBLE PARTY? RELATIONSHIP ADDRESS CITY ZIP PHONE#

IS THIS WORKMAN’S COMP INJURY? YES/NO DATE OF INJURY \_\_\_\_\_  
EMPLOYER AT TIME OF INJURY \_\_\_\_\_ PHONE: \_\_\_\_\_  
CONTACT PERSON: \_\_\_\_\_ DATE LAST WORKED: \_\_\_\_\_  
CLAIM NUMBER \_\_\_\_\_ ARE YOU WORKING NOW? YES / NO

INSURANCE COMPANY NAME: POLICY # GROUP #

ADDRESS: CITY STATE ZIP PHONE #

All professional services rendered are the responsibility of the patient. As a courtesy we will submit billing to your insurance company. All copays and balances not paid after 60 days from date of service become the responsibility of the patient, including any office visits and procedures in/out of the office. By signing below you authorize Surgical Associates to provide information to your insurance company and authorize payment for services rendered:

SIGNATURE

DATE

**GENERAL REVIEW OF SYSTEMS: (CIRCLE ALL YES ANSWERS)**

HIGH BLOOD PRESSURE/LOW BLOOD PRESSURE/**UNCONTROLLED BLOOD PRESSURE**

HIGH CHOLESTROL/**DIABETES**

NUMBNESS OR TINGLING IN ARMS, LEGS , HANDS OR FEET

HISTORY OF STROKE, TIA OR TRAUMATIC BRAIN INJURY

**HEART ATTACK** – WHEN?\_\_\_\_\_

LAST STRESS TEST \_\_\_\_\_/CARDIOLOGIST \_\_\_\_\_

**ANKLE OR LEG SWELLING/HEART FAILURE/LAST ECHO**\_\_\_\_\_

**CHEST PAIN AT REST OR WITH EXERTION**

HISTORY OF HEART CATH OR STENT / HEART SURGERY / PACEMAKER – WHEN?\_\_\_\_\_

HEARTBURN – HOW TREATED?\_\_\_\_\_

IRREGULAR OR FAST HEARTBEAT / FAINTING SPELLS / HEART MURMUR

**PAIN IN CALVES WITH WALKING**

SLEEP APNEA – OXYGEN – CPAP/BIPAP

ASTHMA/WHEEZING/PNEUMONIA/COPD/EMPHYSEMA/CHRONIC BRONCHITIS

HISTORY OF CANCER WHEN?\_\_\_\_\_WHERE?\_\_\_\_\_

THYROID DISEASE/LIVER DISEASE/ JAUNDICE/HEPATITIS

KIDNEY DISEASE/RECURRENT BLADDER INFECTIONS/KIDNEY STONES

URINE INCONTINENCE OR RETENTION

PANCREATITIS/DIARRHEA/COLITIS/GERD/PEPTIC ULCER DISEASE

MUSCLE WEAKNESS/ARTHRITIS – WHERE?\_\_\_\_\_

BLOOD CLOTS/EXCESSIVE BLEEDING/SICKLE CELL ANEMIA

CHRONIC HEADACHES/DEPRESSION/ANXIETY/CHRONIC PAIN ISSUES

SMOKER-HOW MUCH \_\_\_\_\_PACKS PER DAY / HOW LONG \_\_\_\_\_YEARS

ALCOHOL CONSUMPTION \_\_\_\_\_DAY/\_\_\_\_\_WEEK

ILLICIT DRUG USE (IE...MARIJUANA, COCAINE, METHAMPHETAMINE)

**NAME**\_\_\_\_\_

**DOB**\_\_\_\_\_

