PATIENT INFORMATION FORM

IMPORTANT: FILL OUT COMPLETELY

PATIENT NAME (LAST – FIRST – MIDDLE)		SEX M F	BIRTH DATE	MARITAL STATUS S M D W
ADDRESS / STREET	CITY	STATE	ZIP CODE	HOME PHONE ( )
NAME OF EMPLOYER	OCCUPATION	WORK PHONE ( )	PATIENT SSN	CELL PHONE ( )
E-MAIL				

PARENT/GUARDIAN/SPOUSE'S NAME (LAST-FIRST-MIDDLE)	BIRTH DATE	SOCIAL SECURITY NUMBER	PHONE #
NEAREST RELATIVE NOT LIVING WITH YOU		PHONE NUMBER	
NEAREST FRIEND NOT LIVING WITH YOU		PHONE NUMBER	

IN CASE OF AN EMERGENCY CONTACT – NAME	RELATIONSHIP	PHONE NUMBER

LANUAGE PREFERENCE- (PLEASE CIRCLE ONE)			ETHNICITY- (PLEASE CIRCLE ONE)	DO YOU WEAR SEATBELTS? Y N
ENGLISH	ITALIAN	RUSSIAN	HISPANIC OR LATINO	DO YOU USE TOBACCO? Y N CURRENT PACKS/DAY_____ YEAR QUIT_____
CHINESE	JAPANESE	SPANISH	NON HISPANIC OR LATINO	DO YOU USE RECREATIONAL DRUGS? Y N TYPE_____
FRENCH	KOREAN	REFUSE	REFUSE	DO YOU USE ALCOHOL? Y N HOW OFTEN? _____
GERMAN	PORTUGUESE			

RACE (PLEASE CIRCLE ONE)

AMERICAN INDIAN & ALASKAN NATIVE
ASIAN
BLACK OR AFRICAN AMERICAN
BLACK HISPANIC OR LATINO
NATIVE HAWAIIAN & OTHER PACIFIC ISLANDER
WHITE
WHITE HISPANIC OR LATINO
REFUSE

FAMILY MEMBER INFORMATION LIVING IN THE SAME HOUSEHOLD

NAME	SEX	BIRTH DATE	NAME	SEX	BIRTH DATE

I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE

_____ _____

SIGNATURE DATE

INSURANCE INFORMATION

POLICY HOLDER NAME _____ ID # _____

Welcome to Our Practice

As a new patient, please fill out the information found below to the best of your ability.

Patient # _____ Physician _____ Date _____

Patient Name _____ Chief Complaint _____

History of Present Illness:

Location _____ (Where is the pain/problem?)

Quality _____ (Example: normal versus abnormal color, activity, etc.)

Severity _____ (How severe is the pain/problem on a scale of 1-5 (5 being the most severe)?)

Duration _____ (How long have you had this pain/problem or when did it start?)

Timing _____ (Does the pain/problem occur at a specific time?)

Context _____ (Where were you at the onset of this pain/problem?)

Associated Signs/ Symptoms _____ (What other associated problems have you been having?)

Modifying Factors _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

Patient Medical History:

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles	❑ No	❑ Yes	Venereal Disease	❑ No	❑ Yes	Blood or Plasma			Mitral Valve	❑ No	❑ Yes
Mumps	❑ No	❑ Yes	Anemia	❑ No	❑ Yes	Transfusions	❑ No	❑ Yes	Prolapse	❑ No	❑ Yes
Chickenpox	❑ No	❑ Yes	Bladder Infections	❑ No	❑ Yes	Back Trouble	❑ No	❑ Yes	Stroke	❑ No	❑ Yes
Whooping Cough	❑ No	❑ Yes	Epilepsy	❑ No	❑ Yes	High or Low			Hepatitis	❑ No	❑ Yes
Scarlet Fever	❑ No	❑ Yes	Migraine Headaches	❑ No	❑ Yes	Blood Pressure	❑ No	❑ Yes	Ulcer	❑ No	❑ Yes
Diptheria	❑ No	❑ Yes	Tuberculosis	❑ No	❑ Yes	Hemorrhoids	❑ No	❑ Yes	Kidney Disease	❑ No	❑ Yes
Smallpox	❑ No	❑ Yes	Diabetes	❑ No	❑ Yes	Asthma	❑ No	❑ Yes	Thyroid Disease	❑ No	❑ Yes
Pneumonia	❑ No	❑ Yes	Cancer	❑ No	❑ Yes	Hives or Eczema	❑ No	❑ Yes	Bleeding Tendency	❑ No	❑ Yes
Rhematic Fever	❑ No	❑ Yes	Polio	❑ No	❑ Yes	AIDS or HIV+	❑ No	❑ Yes	Any Other Disease	❑ No	❑ Yes
Heart Disease	❑ No	❑ Yes	Glaucoma	❑ No	❑ Yes	Infectious Mono	❑ No	❑ Yes	(please list) _____		
Arthritis	❑ No	❑ Yes	Hernia	❑ No	❑ Yes	Bronchitis	❑ No	❑ Yes			
						Date of last chest X-ray: _____					

Previous Hospitalization/Surgeries/Serious Illness When Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications (include nonprescription):

_____

Patient Social History:

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Use of Tobacco: ❑ Never ❑ Previously, but quit: _____ ❑ Current packs/day _____

Use of drugs: ❑ Never ❑ Type/frequency: _____

Excessive exposure at home or work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Airborne particles ❑ Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

PLEASE FILL OUT BOTH SIDES

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

Good general health lately	❑ No	❑ Yes
Recent weight change	❑ No	❑ Yes
Fever	❑ No	❑ Yes
Fatigue	❑ No	❑ Yes
Headaches	❑ No	❑ Yes

EYES

Eye disease or injury	❑ No	❑ Yes
Wear glasses/contact lenses	❑ No	❑ Yes
Blurred or double vision	❑ No	❑ Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	❑ No	❑ Yes
Earaches or drainage	❑ No	❑ Yes
Chronic sinus problems or rhinitis	❑ No	❑ Yes
Nose bleeds	❑ No	❑ Yes
Mouth sores	❑ No	❑ Yes
Bleeding gums	❑ No	❑ Yes
Bad breath or bad taste	❑ No	❑ Yes
Sore throat or voice change	❑ No	❑ Yes
Swollen glands in neck	❑ No	❑ Yes

CARDIOVASCULAR

Heart trouble	❑ No	❑ Yes
Chest pain or angina pectoris	❑ No	❑ Yes
Palpitation	❑ No	❑ Yes
Shortness of breath walking or lying flat	❑ No	❑ Yes
Swelling of feet, ankles or hands	❑ No	❑ Yes

RESPIRATORY

Chronic or frequent coughs	❑ No	❑ Yes
Spitting up blood	❑ No	❑ Yes
Shortness of breath	❑ No	❑ Yes
Wheezing	❑ No	❑ Yes

GASTROINTESTINAL

Loss of appetitie	❑ No	❑ Yes
Change in bowel movements	❑ No	❑ Yes
Nausea or vomiting	❑ No	❑ Yes
Frequent diarrhea	❑ No	❑ Yes
Painful bowel movements or constipation	❑ No	❑ Yes
Rectal bleeding or blood in stool	❑ No	❑ Yes
Abdominal pain	❑ No	❑ Yes

GENITOURINARY

Frequent urination	❑ No	❑ Yes
Burning or painful urination	❑ No	❑ Yes
Blood in urine	❑ No	❑ Yes
Change in force of strain when urinating	❑ No	❑ Yes
Incontinence or dribbling	❑ No	❑ Yes
Kidney stones	❑ No	❑ Yes
Sexual difficulty	❑ No	❑ Yes
Male - testicle pain	❑ No	❑ Yes
Female - pain with periods	❑ No	❑ Yes
Female - irregular periods	❑ No	❑ Yes
Female - vaginal discharge	❑ No	❑ Yes

Female - # of pregnancies: _____

Female - # of miscarriages: _____

Female - date of last pap smear: _____

MUSCULOSKELETAL

Joint pain	❑ No	❑ Yes
Joint stiffness or swelling	❑ No	❑ Yes
Weakness of muscles or joints	❑ No	❑ Yes
Muscle pain or cramps	❑ No	❑ Yes
Back pain	❑ No	❑ Yes
Cold extremities	❑ No	❑ Yes
Difficulty in walking	❑ No	❑ Yes

INTEGUMENTARY (Skin, Breast)

Rash or itching	❑ No	❑ Yes
Change in skin color	❑ No	❑ Yes
Change in hair or nails	❑ No	❑ Yes
Varicose veins	❑ No	❑ Yes
Breast pain	❑ No	❑ Yes
Breast lump	❑ No	❑ Yes
Breast discharge	❑ No	❑ Yes

NEUROLOGICAL

Frequent or recurring headaches	❑ No	❑ Yes
Light headed or dizzy	❑ No	❑ Yes
Convulsions or seizures	❑ No	❑ Yes
Numbness or tingling sensations	❑ No	❑ Yes
Tremors	❑ No	❑ Yes
Paralysis	❑ No	❑ Yes
Head injury	❑ No	❑ Yes

PSYCHIATRIC

Memory loss or confusion	❑ No	❑ Yes
Nervousness	❑ No	❑ Yes
Drepression	❑ No	❑ Yes
Insomnia	❑ No	❑ Yes

ENDOCRINE

Glandular or hormone problem	❑ No	❑ Yes
Excessive thirst or urination	❑ No	❑ Yes
Heat or cold intolerance	❑ No	❑ Yes
Skin becoming dryer	❑ No	❑ Yes
Change in hat or glove size	❑ No	❑ Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	❑ No	❑ Yes
Bleeding or brusing tendency	❑ No	❑ Yes
Anemia	❑ No	❑ Yes
Phlebitis	❑ No	❑ Yes
Past transfusion	❑ No	❑ Yes
Enlarged glands	❑ No	❑ Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to		
Penicillin or other antibiotics	❑ No	❑ Yes
Morphine, Demerol, or other narcotics	❑ No	❑ Yes
Novocain or other anesthetics	❑ No	❑ Yes
Asprin or other pain remedies	❑ No	❑ Yes
Tetanus antitoxin or other serums	❑ No	❑ Yes
Iodine, methiolate or other antiseptics	❑ No	❑ Yes

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the qustions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X _____ _____

Signature of patient (or parent if minor) Date

Doctor's Review: _____

Signature of Doctor Date

DR. RIPLEY HOLLISTER, M.D., P.C.
FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our commitment is to provide quality treatment for you. Please understand that payment of your bill is considered a part of your partnership in treatment. This is a statement of our Financial Policy. We require you to read and sign this prior to treatment.
All patients must complete our Information and Insurance forms before being seen at this office.
Full payment for services and/or co-insurance payment is due at the time of service. We accept cash, checks, VISA/MASTERCARD or DISCOVER card.

Regarding Insurance
We may accept assignment of insurance benefits if your insurance is accepted at this office. Any remaining balance is your responsibility. In order for us to bill your insurance company you must give us current and correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance policy.
Regarding Insurance Plans in which we are a participating provider: All co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan for which we are not participating providers, refer to the above paragraph.

Collections and Billing
1. Our billing cycle occurs at the end of every month.
2. A $5.00 rebilling fee will be added to any account, if it is necessary to submit a bill to the patient; this is simply to cover our costs (postage, employee time, etc.) incurred in billing.
3. Unfortunately, at times in the past, some patients have not been responsible about paying their Doctor bills. If an account has been billed for 3 months without payment or sufficient cooperation on the part of the patient, the account is turned over to collections.
4. Any overdue account that is turned over to collections will be charged an additional 33.3% to cover collections costs.
5. We will not intentionally turn any account over to collections if the patient is cooperating and making an effort to keep his/her account current.
6. If you think there has been an error on your account you must notify us within 30 days and we will make every effort to correct the situation.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients
The parents or guardians of any minor seen in this office are responsible for full payment. For unaccompanied minors, non-emergency treatment cannot be delivered unless consent for treatment has been given and charges have been pre authorized to a VISA/MASTERCARD or DISCOVER card, or payment of cash or check at the time service has been verified.

Missed Appointments
Please help us to serve you by keeping scheduled appointments. If you will be unable to keep your scheduled appointment, you must cancel it on the preceding day. If an appointment is missed and not canceled by the preceding day, our policy is to charge $10.00 for a regular appointment and $30.00 for a 30-minute visit.

Medical Records Release and Statement of Understanding
I hereby authorize the release of any medical information required by my health plan. I hereby agree to abide by the above "Financial Policy".

_____ _____
SIGNATURE of PATIENT or PARENT/GUARDIAN *NAME OF PATIENT (PRINT)*

_____
DATE

Acknowledgement of Receipt of Notice

Dr. Ripley Hollister

4190 E. Woodmen Rd., Suite 200, Colorado Springs, CO 80920

Julie, Office Manager 719-265-6464

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate.

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

***For Office Use Only*:**

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____