Ross E. Dickstein, M.D.
Phone: (970) 668-1100   Fax: (970) 668-1140

Date of Birth________________________Male:_______ Female: ________ Social Security Number: ____

Name: ____ PO Box: ____

Street Address: ____ City/State/Zip:____

Home Phone: ____ Married_______ Single_______Divorced_______Widowed________

Cell Phone: ____ If Applicable, Spouse's Name____

Fax Number: ____ Email: ____

If You Are From Out Of Town, Phone Number Where You Are Staying:____

EMPLOYMENT INFORMATION

Occupation: ____

Employer: ____Employer Phone: ____

EMERGENCY CONTACT, NOT LIVING WITH THE PATIENT

Name: ____ Phone:_____________________ Relationship:__________________________________

____

INSURANCE INFORMATION

Name of Insurance: ____ Insured Name: ____

Insured DOB: _____________________ Insured SSN: _______________________________ ID Number: ____

Relationship To Patient:______________________ Group Name:____

Group Number: _______________________________ Insurance Phone Number: ____

Today's Date: ___________________________________

Referring Physician: ____

MRI: Y   N   If yes: Lumbar   Thoracic   Cervical

Where: ____   When: ____

MAY A MESSAGE BE LEFT ON YOUR ANSWERING MACHING OR WITH FAMILY REGARDING YOUR APPOINTMENT?   Y______   N______

General Comments:

PEAK ONE PAIN AND SPINE
Ross E. Dickstein, M.D.

SOCIAL HISTORY

Marital Status: __Married __Single __Divorced __Widowed __Living with Significant Other __Living Alone
Tobacco Use: __Yes __No Type:______________________ Duration:____________________ Quit Date:____________________
Alcohol Use: __Yes __No Frequency:____
Recreational Drug Use __Yes __No Frequency:____
Occupation____

PAST SURGICAL HISTORY

Please list all surgeries that you have had in the past

TYPE OF SURGERY	DATE	SURGEON

PAST MEDICAL HISTORY

Check if you currently suffer from or have previously suffered from:

	When?		When?
☐ High Blood Pressure		☐ Kidney Disease / Problems	
☐ Diabetes		☐ Seizures	
☐ Liver disease		☐ Rheumatoid Arthritis	
☐ Heart Disease		☐ Osteoarthritis	
☐ Stroke		☐ Thyroid Disease	
☐ Cancer		☐ Tuberculosis	
☐ High Lipids (cholesterol)		☐ Psoriasis	
☐ Ulcer disease		☐ Polio	
☐ Gastritis		☐ Rheumatic Fever	
☐ Reflux Disease (GERD)		☐ Gout	
☐ Asthma		☐ Depression	
☐ Osteoprosis		☐ Blood Clots	

☐ Others? Please List:____
Have you ever had a blood transfusion? __Yes __No If yes, when?_____________________________________

ALLERGIES

Are you allergic to any medication? __Yes __No Please List:____
____
____
____
Please list all food allergies:____
____
Are you allergic to: Latex? __Yes __No

MEDICATIONS

Please list all medications that you are taking. Include antibiotics, blood thinners, insulin, heart medications, asprin, and any other over the counter medications. Also include vitamins, mineral and herbal supplements.

Medication	Dosage	Frequency

FAMILY HISTORY

Please check family history conditions:

☐ Blood Clots	☐ Diabetes	☐ Hypertension	☐ Rheumatoid Arthritis	☐ Seizures
☐ Cancer	☐ Heart Disease	☐ Osteoprosis	☐ Stroke	

Please describe any immediate family history medical problems:____
____
____

REVIEW OF SYSTEMS

1. Constitutional General — ☐ None ☐ Recent Weight Change ☐ Chills ☐ Fever ☐ Weakness / Fatigue
   ☐ Other____________________

2. Eyes — ☐ None ☐ Vision Change ☐ Glasses / Contacts ☐ Cataracts ☐ Glaucoma
   ☐ Other____________________

3. Ears, Nose, Throat — ☐ None ☐ Loss of Hearing ☐Ear Ache / Infection ☐ Ringing in Ear ☐ Hoarseness
   ☐ Other____________________

4. Cardiovascular — ☐ None ☐ Chest Pain ☐ Swelling in Legs ☐ Shortness of Breath ☐ Palpitations
   ☐ Other____________________

5. Respiratory — ☐ None ☐ Shortness of Breath ☐ Wheezing / Asthma ☐ Frequent Cough
   ☐ Other____________________

6. Gastrointestinal — ☐ None ☐ Heartburn ☐ Acid Reflux ☐ Nausea / Vomiting
   ☐ Other____________________

7. Musculoskeletal — ☐ None ☐ Arthritis / Joint Stiffness ☐ Muscle Aches ☐ Swelling of Joints
   ☐ Other____________________

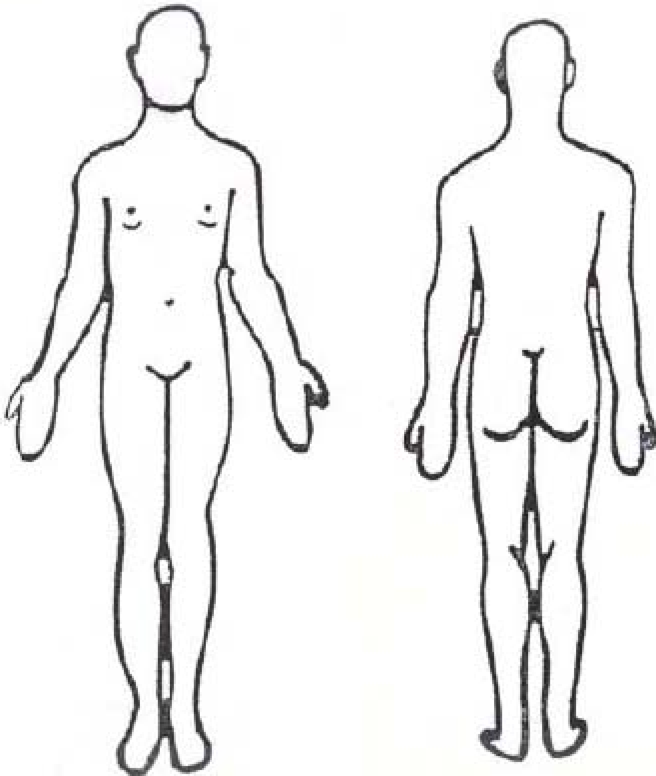
8. Skin — ☐ None ☐ Rash ☐ Ulcers ☐ Abdominal Scars ☐ Sores
   ☐ Other____________________

9. Neurological — ☐ None ☐ Headaches ☐ Fainting / Blackouts ☐ Numbness / Tingling / Loss of Sensation in Any Part of the Body ☐ Dizziness
   ☐ Other____________________

10 Psychiatric — ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swing
   ☐ Other____________________

11. Endocrine — ☐ None ☐ Excessive Thirst or Hunger ☐ Hot / Cold Intolerance ☐ Hot Flashes
   ☐ Other____________________

12. Hematological — ☐ None ☐ Easy Bruising ☐ Easy Bleeding ☐ Anemia
   ☐ Other____________________



Please mark the locations where pain is located.

OFFICE USE ONLY

BP________________

O2________________

P ________________

T ________________

HT________________

WT________________

______________________________ Patient Signature

______________________________ Date

______________________________ Printed Patient Name

______________________________ Physician Initials / Date

PEAK ONE PAIN AND SPINE

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PO Box 2010, Frisco, CO 80443 Phone: (970) 668- 1100 Fax: (970) 668-1140

Health Insurance Portability & Accountability Act (HIPAA)

1. **To whom may we release any or all medical information about you? Please list.**

   ____

2. **Who can we contact in case of any emergency? Name and phone number:**

   ____

3. **May we leave messages on your answering machine?_____Y_____N**
4. **May we contact you at work?_____Y_____N**
5. **Do you want your mail sent confidential?_____Y_____N**

Acknowledgment of Notice of Privacy Practices

____ _________________________
Name of patient (Please Print) Date of Birth

I hereby acknowledge that I received Alpine Anesthesia and Pain Management's Notice of Privacy Practices.

____ ____________________
Signature of patient or patient representative Date

Documentation of Good Faith Efforts

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

The patient presented to the office on _______________________ and was provided with a copy of Alpine Anesthesia and Pain Management'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:

1. Patient refused to sign.
2. Patient was unable to sign because:____
3. Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
4. Other:____
   Mail Return____No Forwarding Address____No Response____No Mail Return____

____ _________________________
Signature of Employee Completing Form Date

NOTICE OF PRIVACY PRACTICES

Peak One Pain and Spine
Ross E. Dickstein, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The terms of this Notice of Privacy Practices describes how Alpine Anesthesia and Pain Management may use your Protected Health information (PHI) to carry out payment and other health care operations and other purposes that are permitted by law.

We are required by the privacy regulations issued under the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 (HIPAA) to maintain the privacy of PHI and to provide our patients with notice of our legal duties and privacy practices concerning your PHI. Listed below is a summary of definitions of how PHI can/cannot be used. We have the right to change these policies and when we do you will be advised accordingly.

DEFINITIONS /USES OF DISCLOSURE

Alpine Anesthesia and Pain Management is permitted by federal privacy laws to make uses of and disclosures of your PHI for purposes of treatment, payment, and health care operations. PHI is the information we create and obtain in providing our services to you. PHI includes but is not limited to information obtained by a physician during an office visit.

OTHER USES AND DISCLOSURES - We can disclose any of your PHI without your authorization for the following:

- We may use or disclose your PHI for any purpose required by law, (i.e.: court order)
- We may disclose any PHI for public health activities such as reporting of a disease, injury, or death for public health investigations.
- We may disclose any PHI to the proper authorities if we suspect child neglect or abuse, or if we believe that you are a victim of abuse neglect.
- We may disclose any PHI to a government oversight agency.
- We may disclose your PHI to proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/ or funeral directors consistent with the law.
- We may disclose your PHI for cadaver organ, eye, or tissue donation.
- We may disclose your PHI for research purposes permitted by law.
- We may disclose your PHI if you are member of the armed forces.
- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization. You may revoke the written authorization at any time.

RIGHTS THAT YOU HAVE

Access to Your PHI-You have the right to copy and/or inspect any of your PHI that we maintain. Certain requests for access must be in writing, must state that you want access to your PHI, and must be signed by you or your Representative.

Amendments to your PHI-You have the right to request that your PHI that we have on record be amended. We are not obligated to make the requested amendments, but we will consider your request and get back to you in a reasonable time frame.

Right to a copy of the Notice-This is your copy of the Privacy Notice, and you must sign the **Acknowledgement of Notice of Privacy Practices** showing that you have received the information from Alpine Anesthesia and Pain Management.

COMPLAINTS

If you have questions, or you would like any additional information regarding HIPAA, or want to report a problem regarding any of your information with Alpine Anesthesia and Pain Management, Please contact Ellen French, Privacy Officer at 970 668 9200. If you feel that your privacy rights have been violated, you may contact the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of the violation of your rights.