New Patient Form

Patient Name: _____ ☐ Female ☐ Male Age: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Cell Phone: _____

Email: _____ SSN: _____

Birth Date: _____ ◯ Single ◯ Married ◯ Widowed

May we give medical information/results to your spouse? ☐ Yes ☐ No

May we leave lab/x-ray results on your answering machine? ☐ Yes ☐ No

Occupation: _____ May we contact you at work? ☐ Yes ☐ No

Employer: _____ Phone #: _____

Address: _____

Referred By: _____ Family MD: _____

Name of Spouse or Parent: _____

Spouse/Parent's SSN: _____ Spouse/Parent's Birthdate: _____

Spouse's Occupation: _____ May we contact him or her at work? ☐ Yes ☐ No

Spouse's Employer: _____ Phone #: _____

Address: _____

Preferred Pharmacy: _____ Address: _____

Person not living in your household in case of an emergency:

Name: _____

Relationship to Patient: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Work Phone: _____

Primary Insurance Name: _____

Policyholder/Spouse Name: _____ Birth Date: _____

Policy ID#: _____ Group Name and/or Military Branch#: _____

Secondary Insurance Name: _____

Policyholder/Spouse Name: _____ Birth Date: _____

Policy ID#: _____ Group Name and/or Military Branch#: _____

To Our Patients:

Fees for services rendered are payable at the time of service unless previous arrangements have been made, or hospitalization is required. We accept assignment for Medicare and most insurance plans. I hereby authorize medical and billing information to be released to my insurance company.

Patient Signature: _____ Date: _____

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New Patient Form | Confidential Health History Questionnaire

Patient Name: _____ Today's Date: _____

Birth Date: _____

Age: _____

Surgeries: (include skin, eye, orthopedic, etc)

Type of Surgery	Month/Year	Type of Surgery	Month/Year
1.		4.	
2.		5.	
3.		6.	

Medical History: (i.e.: ulcers, stroke, high blood pressure, arthritis, thyroid, cholesterol, etc.) Please list the medical problem that prompted you to see the doctor.

Type of Problem	Approximate Date of Onset	Type of Problem	Approximate Date of Onset
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Last Menstrual Period: _____ Number of Pregnancies _____ G P A L

Colonoscopy (date): _____ Last Mammogram Date: _____

Date of Last Pnuemo Vac: _____ Last Pap Test Date: _____

Date of Last Flu Vac: _____ Date of Last Bone Density: _____

Date of Last Shingles Vac: _____ Date of Last Full Physical Exam: _____

Current Medications: (include over-the-counter medications)

Name	Dose (mg)	How Often/Day	Name	Dose (mg)	How Often/Day
1.			5.		
2.			6.		
3.			7.		
4.			8.		
9.			10.		

Drug Allergies:

Name of Drug	Type of Reaction (i.e. rash, hives, shortness or breath, upset stomacn, etc)

Habits:

Dietary restrictions or special diet: _____

How many cups of coffee or other caffeinated beverages do you drink per day? _____

Do you use tobacco? _____ Did you use tobacco in the past? _____ What year did you quit? _____

How many packs per day? _____ How many years total have you used? _____

Do you drink alcohol? _____ How much per day? _____ Type? _____

Have you ever used intravenous drugs? (this information will remain confidential) _____

Please check one: ☐ Heterosexual ☐ Bisexual ☐ Homosexual

Calcium Intake: Supplements/Dairy Products (amount, type, frequency _____

Exercise: Type _____ Duration: _____ Frequency: _____

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New Patient Form | Confidential Health History Questionnaire (continued)

Family History: (Cancer, Diabetes, Dementia, Coronary Disease, Osteoporosis, Other)

	Deceased or Living	Age (current or at death)	Diagnosis or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	

# of Sons _____ illnesses _____

# of Daughters _____ illnesses _____

Social History:

Occupation: _____ Are you retired? _____

Marital Status: _____ How Long? _____

Date of Last Full Physical: _____ Toxic Chemical Exposures: _____

Hobbies: _____

Medical Illnesses and Symptom Review: (Please check the box if you have had any of the following illnesses or symptoms.)

- ☐ Recent fever
- ☐ Recent weight gain
- ☐ Excess fatigue or weakness
- ☐ Diabetes
- ☐ Thyroid or other hormonal problem
- ☐ Any type of cancer
- ☐ Anemia or other blood disorder
- ☐ Previous blood transfusion
- ☐ Skin rash or unusual mole
- ☐ Glaucoma or other eye problem
- ☐ Recent ear, nose or throat problem
- ☐ Hay fever or sinusitis
- ☐ Exposed to excess dust, toxic chemicals or fumes
- ☐ Chronic lung disease or asthma
- ☐ New or chronic cough
- ☐ Unusual shortness of breath with moderate activity or exercise
- ☐ Shortness of breath caused by lying flat
- ☐ Swelling in feet or ankles
- ☐ High blood pressure
- ☐ High cholesterol/triglycerides
- ☐ Any type of heart disease
- ☐ Previous heart attack
- ☐ Previous heart murmur
- ☐ Recurrent chest pain/discomfort
- ☐ Palpitation or irregular pulse
- ☐ Leg cramps when walking
- ☐ Blood clot in leg or lung
- ☐ Recent abdominal pain
- ☐ Recent nausea or vomiting
- ☐ Change in bowel movements
- ☐ Recent blood in stool/black stools
- ☐ Heartburn or hiatal hernia
- ☐ Stomach or duodenal ulcer
- ☐ Spastic colon, diverticulosis, or recurrent colitis
- ☐ Polyp or tumor of the colon
- ☐ Hepatitis or liver disease
- ☐ Any problem with urine flow, frequency or unusual color
- ☐ Kidney stones
- ☐ Infection of kidney or bladder
- ☐ Sexually transmitted disease
- ☐ Serious sexual dysfunction
- ☐ Previous prostate problem
- ☐ Recent menstrual problem
- ☐ Any breast problems
- ☐ Arthritis or painful joints
- ☐ Chronic or new back pain
- ☐ Difficulty walking
- ☐ Recent dizziness
- ☐ Passing out or fainting spells
- ☐ Previous stroke
- ☐ Seizures or tremor
- ☐ Headaches
- ☐ Feelings of depression
- ☐ Excess stress or anxiety
- ☐ Problems with memory, concentration, forgetfulness

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New Patient Form | Authorization for Use or Disclosure of Imaging Information

This authorization for use or disclosure of my health information is required by Federal and state law.

Patient Name: _____ Birth Date: _____

Daytime Telephone: _____ SSN: _____

I hereby Authorize the Use or Disclosure of My Health Information to:

_____

Name of organization releasing information

_____

Street Address

_____

City State Zip Code

To Release my Health Information to: **Stuart B. Kipper, MD**
700 Garden View Court, Suite 200
Encinitas, CA 92024

This Authorization Applies to the Following Information:

☐ All records ☐ Lab ☐ Imaging Reports ☐ Immunization

☐ Other: _____

The Recipient May Use My Health Information Only for the Following Purpose:

_____

(Please Specify)

A specific authorization is required to release information regarding the following:

HIV Information	☐ Yes	☐ No	_____ Initials
Drug/Alcohol Information	☐ Yes	☐ No	_____ Initials
Mental Health Information	☐ Yes	☐ No	_____ Initials

I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address at the bottom of this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorizations was valid.

I have a right to a copy of this authorization. Copy requested? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Patient/Personal Representative Signature: _____

Relationship to Patient: _____

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New Patient Form | Fees and Policies

We are committed to providing you with the very best of health care. Please read this form and sign at the bottom.

Financial Policy:
Payment for services is due at the time of service. We accept cash, checks, Mastercard and Visa. We will gladly file your insurance claims if you are a member of a health plan with which we are contracted.

Please remember:

- Your insurance is a contract between you, your employer and the insurance company.
- Not all services are a benefit of your contract.
- Non-covered services are your responsibility.
- There may be an invoicing charge of $25.00 if your co-pay or other fees are not paid at the time of service.

Medical Records:
Medical Records are the property of Stuart B. Kipper, M.D. and Associates. You have the right to review your records or request a copy of it. The charge to copy your record is to be paid in advance.

Copy of entire record to new primary physician is $25.00.

Medical Correspondence:
Written correspondence for various purposes is available for a fee.

Form fees:

• DMV forms (excluding Handicap placard forms)	$75.00
• Disability forms	$75.00
• School physician form	$75.00
• Assisted Living admission form	$75.00
• Other detailed forms	$75.00

Cancellations and Missed Appointments:
24-Hour notice is required for cancellations. Missed appointments or less than 24-hour notice will be assessed. The following charges are to partially recover our staffing costs and reserved physician's time.

• New Patient Missed Appointment	$100.00
• Follow-Up Missed Appointments	$75.00

I have read and understand the above statements and agree to abide by these policies.

Signature: _____ Date:_____

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New Patient Form | Fees and Policies

Stuart B. Kipper M.D. and Associates is a provider for many insurance plans and will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. However, to avoid any confusion, be aware that we do expect payment of any applicable deducible, co-payments or co-insurance amounts at the time of service. Also, any services that your insurance will not cover are your responsibility.

If your insurance requires prior authorizations for any of your treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred. If your insurance subsequently authorizes today's services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will still bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to pay us until after the insurance has paid its portion providing the insurance company pays us within 30 days.

If you do not have insurance, payment is expected at the time of service. We accept Visa and Mastercard for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms, (such as for disability, Department of Motor Vehicles, or other physician report forms), there will be a $**75.00 fee per form.**

Statements are mailed monthly to patients with an outstanding balance. We may assess interest at the rate of 1% per month on all accounts over 60 days. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 598-1700 to make payment arrangements, unless a payment schedule already exists.

If you must cancel your appointment, please give us at least 24-hours' notice so we can schedule another person in your place. There is a **Missed Appointment Fee of $75.00** charged for appointments not cancelled with the 24-hours notice. This fee will be waived if a phone call is received within the specified timeframe or if documentation of an emergency can be provided.

Billing Office hours are 8:30am to 4:30pm, Monday through Friday. If you reach our voicemail, please leave a detailed message and we will return your call as soon as possible.

Thank you for choosing Stuart B. Kipper, M.D. and Associates.

I have read and understood Stuart B. Kipper M.D. and Associates financial and claims filing policies.

PRINT PATIENT NAME: _____

Signature: _____ Date:_____

Responsible Party Signature: _____ Date:_____

Reset Form | Save to My Computer | Email to Dr. Kipper | Print at Home

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