ALPINE WOMEN'S CENTRE
MONTROSE MEMORIAL HOSPITAL

715 South 3rd St.
Montrose, CO 81401
Phone 970.249.6737
Fax 970.252.0112

Richard G. Hanley, M.D., F.A.C.O.G James N. Gilham, D.O., F.A.C.O.G
Derick A. Fenton, M.D., F.A.C.O.G Meg Benasutti, A.N.P. Sheena Wisler, M.D.

Patient Forms

Please fill out these forms so we can expedite your visit

What to Bring

New patients should arrive 15 minutes early prior to your scheduled appointment time to complete your registration.

Please bring in the items to the appointment:

- Insurance card(s) or Sliding Scale card
- Driver's License or ID
- Any required co-payment
- Patient Forms

What to Expect

During the first visit, we will obtain important background information, like your medical history and give you time to get to know your provider. Being well prepared for your appointment will ensure that the provider has all the needed information to provide the best possible care for you. We look forward to your first visit.

Insurance

We accept and participate in most insurance plans, including Medicaid. Since there are so many different insurance plans, it is the patient's responsibility to understand their own policy. Copayments are due at the time of service. We will bill your insurance and you are responsible for any unpaid balance not covered by insurance.

Self Pay

Payment is expected at the time of your visit. We accept cash, checks and credit/debit cards. In the event payment cannot be made, you will need to sign a mutually satisfactory payment plan. A 25% discount will be applied for services paid in full at the time of service.

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WELCOME TO OUR OFFICE

Today's Date _____ Marital Status ( )M ( )S ( )W ( )D

Name _____ Birthdate _____
First MI Last

Mailing Address _____

City _____ State _____ Zip _____ Social Security # _____

Email _____ Pharmacy _____
(If City Market-Please indicate North or South)

Phone # _____ Work or Message Phone _____

Employer _____ Occupation _____

Primary Care Doctor _____ Phone _____

Insurance Company _____ Subscriber # _____

Policy Holder _____ DOB ___/___/___

SS# _____ Relationship to Patient _____

Emergency Contact _____ Relationship _____Phone _____
(First and Last Name)

I authorize ALPINE WOMEN'S CENTRE at MMH to discuss my medical diagnoses/test results/treatment plan and financial account with:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Signature _____Date _____

Rev. 10/22/2019

Alpine Women's Centre

Patient Portal Registration Form

The Patient Portal provides secure online access to portions of your MMH Provider Clinic Medical Record.

Patient Name: _____

Patient's Date of Birth: _____

Designated User Name: _____ (if applicable – Designee must be 18 or older)

E-mail Address: _____
(each patient must have his/her own email address, one per account)

By signing and dating this form, I am authorizing Montrose Memorial Hospital Provider Clinics to create a patient portal Login ID and password for the patient or Designated User listed above. I understand that this information will be emailed to me or my Designated User within 3 business days at the email provided above. I understand that I may at any time revoke this access by contacting the clinic. My Designated User will have access to my Patient Portal records until that time. By signing the form below, I understand that records accessed by my Designated User may be redisclosed without my knowledge and are no longer protected by state or federal privacy regulations. I further understand that information in the Patient Portal may include treatment and testing regarding drug/alcohol abuse, mental health, HIV status, genetic testing and reproductive medicine.

Signature:_____ **Date:** _____

Office use only: ID Verified_____ Date Received_____ Date User Created_____ Initial_____

Montrose Memorial Hospital Provider Clinics Patient Portal Information

Patient Portal access is not available to minor patients' Designated Users. Portal access is available for patients ages 18 and older.

Once the registration form is completed and returned to the front desk, you will receive an email with a link to the patient portal (within 3 business days). The print out and email will include your login ID and one-time password information. Please make sure you check your bulk, junk or spam email, because it may have filtered there. Once you receive your login ID and one-time password, please follow the prompts. Copy and paste your password into the field. You will then be prompted to create a new password and select or create your security question and answer. You will need to read and accept the Terms and Conditions of the patient portal before it can be accessed.

Whenever a new item is posted to your patient portal, such as results, reports, appointments etc., you will receive an email notification. There will be a link at the bottom of the email directing you to the portal log in screen. No health information is relayed in any email. All email addresses will be kept confidential and will not be used for marketing or solicitation.

On or after August 1, 2018 you can visit www.montrosehospital.com to access your portal or learn more about the patient portal.

ALPINE WOMEN'S CENTRE
MONTROSE MEMORIAL HOSPITAL

HEALTH SUMMARY FORM

NAME: _____ ***DOB***: ____/_____/_____ ***DATE***: ____/____/____

Current Medications/Supplements (and Dosage) **N/A_____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Medical History (current/chronic conditions) **N/A_____

_____ _____ _____ _____ _____

Allergies (Drug/Environmental) **N/A_____

_____ _____ _____ _____ _____

Gynecologic History

Are you currently sexually active? _____ If so, how long have you been with the same partner? _____
Date of last Pap smear____/____ Abnormal Pap smear? _____ If so, what year? _____
Date of last mammogram____/____ Date of last colonoscopy (over age 50) _____/_____
Do you perform routine self-breast exam? _____
First Day of Last Menstrual Period ____/____/____ Age at first period _____
Do you have/have you had a sexually transmitted disease?_____
Birth control: Pills/NEX/IUD?_____ Tubal Ligation?_____ Vasectomy?____

History of Pregnancies **N/A_____ Number of pregnancies _____

Year	Vag/C-Sect, miscarr, abort	Complications	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgical History **N/A_____

Year	Surgery	Surgeon
____	_____	_____
____	_____	_____
____	_____	_____

Hospitalizations (other than for surgeries) **N/A_____

Year	Reason	Location
____	_____	_____
____	_____	_____

Family History Do you have a mother or sister with breast or ovarian cancer? Yes / No
Do you have a mother, father, sister or brother with colon cancer? Yes / No
Please list conditions/diseases of blood relatives in your immediate family:

Condition/Family Member	Condition/Family Member
_____	_____
_____	_____

Social History Do you drink alcohol? Yes ___ / No _____ //// _____ per day ___/week____
Do you smoke? Yes___ / No ____ // ____pack(s) per day for ____ year(s) What year did you quit? _____
Have you used street drugs within the past 5 years? Yes___ / No ____

Personal Health History (current or previous) Please circle all that apply. **N/A_____

Hot Flashes Sleep Disturbance Stroke Seizure Headaches Anxiety Depression High Blood Pressure High Cholesterol Ulcer Anemia Liver Disease Colitis Blood in Stool Gallstones Kidney Disease Kidney Stones Heart Attack Heart Murmur Palpitations Blood Clot Lupus Asthma Emphysema Bronchitis Tuberculosis Skin Disease Arthritis Scoliosis Osteoporosis Osteopenia Diabetes Thyroid Disease Abuse (type) _____ Cancer (type) _____

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Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name:_____ Date of Birth:_____ Age:_____
Height:_____ Weight:_____ Age of First Period:_____
Age when had First Child (if applicable):_____ Age at Menopause (if applicable):_____
Have you ever used Hormone Replacement Therapy? Yes or No IF YES, for how many years?_____
Has anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please mark below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship AND age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins. ANSWER ALL QUESTIONS AND INCLUDE YOURSELF AND AGE AT DIAGNOSIS

			You	Siblings/Children	Mother's Side	Father's Side
Y	N	EXAMPLE	37	SISTER-43 years old	AUNT-55 y/o	GRANDMA-55 y/o
Y	N	1 case of Breast cancer *under age 46*				
Y	N	2 cases of Breast cancer one *under age 51*				
Y	N	Ovarian cancer *at any age*				
Y	N	Male Breast cancer at any age				
Y	N	Are you of Ashkenazi Jewish descent?				
Y	N	Breast cancer diagnosis with Triple Negative Receptors: ER-, PR-, and HER2-*under age 6*				
Y	N	Any 3 cases of Breast, Ovarian, aggressive Prostate cancer, or Pancreatic cancer *at any age in your family*				
Y	N	Have you had Uterine (endometrial) cancer o Colon cancer *before age 51*				
Y	N	Uterine cancer *before age 51*				
Y	N	Colon cancer *before age 51*				
Y	N	2 or more Uterine or Colorectal cancers (in an individual or family)				
Y	N	Uterine, and/or Colorectal cancer AND Ovarian, Stomach, Kidney/Urinary tract, brain OR Small bowel cancer (in an individual or family)				

LIST ANY OTHER FAMILY MEMBERS OR YOURSELF WITH CANCER THAT DID NOT FIT CRITERIA ABOVE:_____
_____

Patient's Signature:_____ Date:_____

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Testing? YES NO

IF YES and patient offered testing, did patient: ACCEPT DECLINE

*Patient signature for declining testing:*_____ *Date:*_____

Follow up appointment scheduled for accepted testing: YES NO

Physician Signature:_____ Date:_____