Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

Welcome to the Denver Center for Endocrine Surgery!

We appreciate the opportunity to participate in your healthcare.

Our team specializes in the surgical treatment of thyroid, parathyroid, pancreas, and adrenal problems. We also treat melanoma and other general surgical conditions. Our goal is to make your surgical experience personal and compassionate, and to minimize the impact on your life.

We look forward to seeing you in our clinic. Please take the following steps and bring the necessary forms to ensure that you are prepared for your visit.

1. Bring your insurance card and a photo ID.

2. Please confirm that your referring physician has sent a request for consultation and all related medical records. **If your insurance requires a written referral/pre-authorization, it is your responsibility to confirm this.**

   Important related medical records may include: relevant labs, pathology reports, x-ray studies, ultrasound reports, thyroid or parathyroid scans, bone density reports, surgical reports, office visit reports, current medications, etc.

3. We accept cash, check, and most major credit cards. If your insurance requires a co-payment and/or payment towards your deductible, it is required at the time of service and will be collected before you see the doctor or PA.

4. Please bring the names and doses (or the bottles) of your current prescriptions.

5. Please fax or email completed registration packet no later than 2 days prior to your appointment, and arrive 15 minutes early. Failure to do so may result in your appointment being rescheduled. Fax: 303-407-0284 Email: Paul.Dupuis@HealthOneCares.com. **Please review and complete the attached forms in advance and bring them to your appointment**:

   a. Patient Registration Form
   b. Patient Medical History Questionnaire (five pages)
   c. Patient Record of Disclosures and Privacy Notice
   d. Financial Policies Agreement

Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last)_____(First)_____(MI)____Previous Name _____

Address Line 1_____City, State_____ZIP _____

Home Phone_____Cell No._____Work Phone_____Ext._____

Primary Care Provider (PCP)_____Referring Provider_____

Pharmacy and address:_____E-Mail Address:_____

Date of Birth MM_____/DD_____/YYYY_____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific ☐ Black/African ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name_____ First Name _____

Phone Number_____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient_____ ☐ Guardian

Address Line 1_____City, State_____ZIP _____

Home Phone_____Work Phone_____Ext. _____

Pharmacy Name, Address, and Phone Number: _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last)_____(First)_____ (MI)_____

Guarantor Account Number_____Date of Birth MM_____/DD_____/YYYY_____

Social Security Number_____-_____-_____Telephone _____

E -Mail Address_____ Sex ☐ F – Female ☐ M - Male

Address Line 1_____City, State_____ZIP _____

Employer_____Employer Phone Number_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____(_____)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____Copay Amount_____ Effective Date_____Termination Date_____Date of Birth MM__/DD____/YYYY_____ **SECONDARY**

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____(_____)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____Copay Amount_____

Effective Date_____Termination Date_____Date of Birth MM_____/DD_____/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

PATIENT HISTORY

Patient Name

_____

Date of Birth_____/_____/_____ Age _____ Height _____
Weight_____

Race_____Ethnicity: (circle one): Non-Hispanic Hispanic/Latino
Preferred Language _____

Reason for Visit: _____
Pain Level (0-10)?_____Location?_____
Duration of Present Complaint or Problem: _____

PLEASE LIST ALL MEDICATIONS/HERBAL SUPPLEMENTS CURRENTLY BEING USED (PLEASE PRINT NEATLY)
If you need more space for your medications, please provide a list on a separate sheet

Name & dose (i.e., 2 mg, 60 mg, etc)	**Frequency (i.e. twice daily, at bedtime)**	**Reason for medication**

PAST MEDICAL HISTORY
Please an X next to any condition with which YOU have been diagnosed, or list other:

□ None	□ GERD / Reflux	□ Adrenal Problems	□ Anesthesia Problems
□ Anemia	□ Glaucoma	□ Bone Fractures	□ Bleeding Disorder
□ Anxiety	□ Heart Disease	□ Diabetes	□ Blood Thinners/Aspiri
□ Asthma	□ Hepatitis	□ History of Steroid Use	□ Chronic Pain
□ Atrial Fibrillation	□ HIV	□ History of Radiation	□ Clotting Disorder
□ Autoimmune Disorder	□ High cholesterol/lipids	□ Hyperthyroid/Overactive Thyroid	□ CVA//TIA/Stroke
□ Enlarged Prostate	□ High Blood Pressure	□ Hypothyroid (underactive thyroid)	□ DVT
□ Cancer – Breast	□ Irritable bowel disease	□ Kidney Stones	□ Hemophilia
□ Cancer – Colon	□ Myocardial infarction	□ Low Bone Density	□ Migraines
□ Cancer – Lung	□ Nasal Allergies	□ Thyroid Nodules	□ Narcotic use > 6 mo
□ Cancer – Prostate	□ Osteoarthritis	□ Other:	□ Pulmonary Embolism
□ Cancer – Skin	□ Renal Disease		□ Seizures

□ Cancer – Other	□ Rheumatoid Arthritis		□ Other:
□ COPD	□ Vision Loss		
□ Depression			
□ Fibromyalgia			

Have you ever been *DIAGNOSED* with any other major health problem not listed above? No Yes
If yes, please list diagnosis and year the diagnosis was made:

ALLERGIES:
Are you allergic to ANY medication, food, or non-medications (such as pollen, etc.)? No Yes
If yes, please list below or on a separate sheet for additional space.

Name of Medication/Food/Agent	**Type of Reaction (i.e. rash, breathing problems, swelling, etc)**	**Date**

SURGERIES:
Have you ever had surgery? No Yes
If yes, list name / type of surgeries and when they were done.

HAVE YOU OR YOUR FAMILY EVER HAD ISSUES WITH ANESTHESIA?: No Yes
If yes, please explain.

HOSPITALIZATIONS:
Have you ever been hospitalized? No Yes
If yes, list dates/reason.

Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

FAMILY HISTORY Please place X in box next to any condition with which a member of your immediate family has been diagnosed: Unknown Adopted None

DISEASE	Mother	Father	Brother	Sister	Son	Daughter	Aunt	Uncle	Other
Thyroid Disease									
Thyroid Cancer									
Parathyroid Disease									
Osteoporosis									
Kidney stones									
MEN/Tumor syndrome									
Anemia									
Blood clots									
Diabetes									
High blood pressure									
Breast Cancer									
Coronary disease									
Lung cancer									
Colon cancer									
Heart attack									
High cholesterol									
Asthma									
Other:									

SOCIAL HISTORY

Do you currently drink alcohol? No Yes
If yes, please list type/how much per week: _____
Do you have history of alcohol abuse? No Yes

Do you currently smoke / use tobacco in any form? No Yes
If yes, what type and how much? _____
When did you start? _____
If yes, have you tried quitting smoking or a counseling program? No Yes
If yes, are you interested in quitting? _____
If no, do you have a history of smoking/tobacco use in the past? No Yes
When did you quit? No Yes
Do you exercise? No Yes
If yes, type and how often? _____

Marital Status: Married Partner Single Divorced Widowed
Who do you live with? _____

Do you currently use any recreational drugs: ……... No Yes
If yes, what type and how often: _____

Employment Status: Employed Unemployed Retired Disabled Self-employed
What is or was your occupation? _____

Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

MEDICAL HISTORY QUESTIONAIRRE

In the last three months, have you experienced the following: (check all that apply)

GENERAL
☐ Chills ☐ Fatigue ☐ Fever

EYES/EARS/THROAT
☐ Blurred vision ☐ Double vision ☐ Itching eyes ☐ Hearing loss ☐ Sore throat ☐ Trouble swallowing

NECK/HEAD
☐ Neck Pain ☐ Neck stiffness ☐ Neck lump/mass ☐ Headache

CARDIOVASCULAR
☐ Chest pain ☐ Palpitations ☐ Swelling of feet

RESPIRATORY
☐ Cough ☐ Short of breath ☐ Wheezing

ABDOMINAL
☐ Abdominal pain ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Heartburn

URINARY
☐ Blood in urine ☐ Pain with passing urine ☐ Hernia or bulge

MUSCLE/BONES
☐ Joint Pain ☐ Muscle Pain ☐ Weakness

SKIN
☐ Rash ☐ Skin lesion ☐ Breast Lump ☐ Breast Pain

NEUROLOGIC
☐ Confusion ☐ Dizziness ☐ Fainting ☐ Numbness ☐ Paralysis ☐ Tingling ☐ Falls ☐ Voice change

PSYCHIATRIC
☐ Anxiety ☐ Depression ☐ Suicidal thoughts ☐ Memory changes ☐ Sleeping problems

ENDOCRINE
☐ Frequent urination ☐ Increased thirst ☐ Cold intolerance ☐ Heat intolerance

HEME/LYMPHATIC

☐ Blood clots ☐ Easy bleeding ☐ Easy bruising ☐ Prior blood transfusion ☐ Weight gain ☐ Weight loss

HEALTH MAINTENANCE:

Date of last routine annual exam _____ With whom? _____
Up-to-date on vaccines? Yes No
Date of last flu vaccine_____
Date of last pneumococcal vaccine_____

Date of last colon cancer screening _____
Date of last colonoscopy _____ Normal? Yes No

Men:
Date of last prostate check _____ Normal? Yes No

Women:
Date of last pap smear _____ Normal? Yes No

Date of last menstrual period _____ Normal? Yes No
Menopause? Yes No Hysterectomy? Yes No

Date of last mammogram? _____ Normal? Yes No

This Information is true and complete to the best of my knowledge.

Signature of Patient or Legal Guardian_____Date___/___/___

Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	**Employee Job Title**
Signature of Witness	**Date**

Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself or your health coverage carrier, **full payment for office services are due at the time of service**.

For you convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or
money order.

About Health Insurance:
Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.

About Participating Health Plans:
We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits.
We will bill those plans with which we have an agreement and will only require you to pay the co-payment **at the time of service**.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

For all service rendered to minor patients we will look to the adult accompanying the patient and parent or guardian with custody for payment.

It is your responsibility to verify that this office participated with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.

By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**

Denver Center for Endocrine Surgery
Dr. Kimberly Vanderveen, Ann Sullivan, PA-C
4700 E. Hale Pkwy, Suite 210 | Denver, CO 80220 | 303.407.0280 | Fax 303.407.0284 | www.denverendosurgery.com

VOICEMAIL AUTHORIZATION

I, the undersigned, authorize the Denver Center for Endocrine Surgery to leave (circle one)

DETAILED OR GENERAL

voicemail messages regarding future appointments, test results and personal information on the number
I specify:

Phone number: (___)_____

Name: _____

_____ _____
Signature **Date**