



Daryl Dutter, M.D. Kent Hufford, M.D. J. Jeffrey Daley, M.D.

PO Box 210 | 150 Vera Avenue Ripon, CA 95366

p: (209) 599-4211 | f: (209) 599-7348 | www.RiponDocs.com

To Our Patients,

Welcome to the family practice office which has served Ripon and surrounding communities since the early 1970's. We look forward to providing you with quality medical care. The following information will help familiarize you with our office.

1. Office Appointments are available from 7:00AM – 6:30PM Monday-Thursday and 7AM - 4PM on Fridays. Phone hours are from 8-12 and 1-5, Monday through Friday. We try to offer same-day appointments, but these are booked quickly, so we advise that you call the office early in the day if you hope to schedule a same-day appointment.
2. Please inform the schedulers of the reason for your appointment so they can allow adequate time for your appointment. Bring your insurance card, copay, and a list of your current medications with you to each appointment.
3. Should you be unable to keep your appointment, please call us at (209)599-4211 to cancel or reschedule, *as soon as possible*.
4. As a convenience to our patients we offer on-site blood draws. You do not need to schedule an appointment for this procedure, however our doctor's lab order must be in your file. Blood draws are performed on a walk-in basis. The lab hours are Monday - Thursday from 7:00AM – 2:00PM; and Friday from 7:00AM – 11:00AM. We do not draw lab tests ordered by outside physicians
5. Yearly physical exams for men over age 50 are advised. Please ask to schedule an "Annual Physical" at our front desk or call (209) 599-4211 x 2.
6. Yearly physical exams are advised for women. If you see a gynecologist, please ask them to forward all reports to our office in order to keep your record complete.
7. Please contact your pharmacy directly when due for a medication refill. They will forward your request to us and we will respond within 48 hours.
8. Visit our website for more information: www.RiponDocs.com

Thank you for coming to us for your health care needs.



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Date _____

Last Name _____ **First Name** _____ **MI** _____

Date of Birth _____ **Gender:** **M / F** **Social Security #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Mailing Address (if different) _____

Primary Phone _____ **Alternate Phone** _____

Email _____ **Communication Preference:** Phone Mail Portal

Occupation _____ **Employer** _____ **Retired** **Student**

Preferred Pharmacy _____

Preferred Language _____ **Other Languages Spoken** _____

Race: White Black Asian Hawaiian Pacific Isle American Indian/Alaskan Other _____

Ethnicity: Non-Hispanic Hispanic

Marital Status: Single Married Divorced Separated Widowed

Emergency Contact _____ **Phone** _____ **Relationship** _____

Emergency Contact _____ **Phone** _____ **Relationship** _____

Primary Insurance _____ **ID#** _____

Policy Holder Name (if different from patient) _____ **Relationship** _____

Policy Holder's Birthdate _____ **Policy Holder's SS#** _____

Other Family Members in Household (if applicable):

Spouse Name _____ **Parent's Names** _____

Children _____

Siblings _____



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Authorization for Release of Medical Information

Patient _____ Birth Date _____

I acknowledge that I have received a copy of the Notice of Privacy Practices (available at our office or on our website, www.ripondocs.com). I understand that I may amend or revoke these authorizations at any time by submitting a signed and dated notice. This authorization will remain valid unless I revise and sign a new form.

I authorize the release of medical information to and from other physicians or medical facilities in order to effectively manage my medical care.

Please check YES or NO:

◆ **Voicemail Messages:** I give permission for the office to leave a voicemail message with appointment information, test results, referrals, recommendations and other messages, on the phone number(s) that I have provided. YES NO

◆ **Mail:** I give permission for the office to mail correspondence including diagnostic test results, scheduling reminders, and other information regarding my health care to the address that I have provided. YES NO

◆ **Authorized Contacts:** I give permission for the office staff to speak with the following individuals regarding my healthcare: NONE, only myself

_____	Phone # _____
_____	Phone # _____
_____	Phone # _____
_____	Phone # _____

◆ **Discretionary Disclosure:** I choose to leave decisions regarding the disclosure of my health care information to the discretion of Dr. Dutter, Dr. Hufford, Dr. Daley and their staff, believing that they maintain the best interest of my health and medical well-being. YES NO

Acknowledgement of Financial Responsibility

◆ I authorize the release of medical and other information necessary to process medical claims. I authorize payment of insurance claims be made to the physician.

◆ I assume responsibility for payment of medical services that are not a covered benefit of my insurance. Covered benefits may be verified by contacting the Customer Service Department of the insurance.

◆ I assume responsibility for charges incurred if correct, current, and complete insurance information is not presented at the time of service.

Signature of Patient/Guardian/Representative _____ Date _____

If this authorization is NOT signed by the patient, complete the following information:

Printed Name _____ Relationship to Patient _____ Representative's Phone # _____



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Medical Records Release Form

ATTN: MEDICAL RECORDS, Please fax records from: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby authorize that you release my medical records to:

Dr. Dutter, Dr. Hufford, and Dr. Daley

PO Box 210 • Ripon CA 95366 • Phone: 209-599-4211 • Fax: 209-599-7348

PRINT Patient's Full Name: _____

Medical Record #	Date of Birth	Phone Number
Address	City	State & Zip

SPECIFIC REQUEST:

X ONE YEAR OF COMPLETE RECORDS, unless specified below (Send the most recent 12 months that the patient was seen)

Additionally:

- Most recent labs
- Most recent Colonoscopy/Endoscopy – with pathology
- Most recent Pap smear pathology
- Most recent Mammogram
- Immunization Record
- Drug/Alcohol/Substance abuse records
- Psychiatric/Mental health records
- HIV/STD results
- Genetic Information

OTHER _____

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____. The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.

Signature _____ Relationship to patient _____

Date _____

Faxed: Date & Initials



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Medical History Form

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it.

Name _____ Date of Birth _____ Today's date _____

1. Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

- | | | | | | |
|-------------------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma/Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney disease/stones | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic diarrhea/IBS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease/Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lung disease/pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diverticulosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pancreatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually transmitted disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, what age? _____ | | | Sleep apnea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy or Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gallstones | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal disease/Syphilis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid disease/Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heartburn/Acid Reflux | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors/Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers (stomach or intestinal) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes to any of the above, please explain _____

When was your last Tetanus shot given? _____

2. Family History

Adopted, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

Family Relationship:

- | | | | | | |
|----------------------|------------------------------|-----------------------------|-------|---------------------------------|--|
| Bowel/Colon Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Breast Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Strokes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Thyroid Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |
| Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased at age _____ |

3. Personal Habits

Tobacco Use

Cigarettes: Never Former Current Smoker (Packs per day _____ # of Years _____ Quit-Date _____)
Other tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? Yes No

Alcohol Use

Do you drink alcohol? No Yes, average # of drinks per week _____
If no, have you in the past? Yes No

Drug Use

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills?
 No Yes (please circle which drugs)
Have you ever used needles? Yes No

Sexuality

Are you sexually active? Yes No Not currently
If sexually active, do you practice safe sex? Yes No
Birth control method _____
Have you ever had any sexually transmitted diseases (STD's)? Yes No
If yes, please include _____

Exercise

Do you exercise regularly? Yes No How many times per week? _____
If yes, what type of exercises? _____

Emotions

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things that you usually enjoyed? Yes No

4. Medications

Please list all your current medications, including medications and supplements not needing a prescription:
Or attach a complete list.

Medication	Dose	Directions	Taken For:	Will our office be refilling?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist

5. Allergies

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect
_____	_____
_____	_____
_____	_____
_____	_____

6. Operations

Have you had any operations? If yes, list:

Type of operation / Reason for operation	Hospital / Facility	Date of operation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. For Women Only

Total # of pregnancies _____ # of deliveries _____ # of miscarriages _____ # of abortions _____

Age at start of menstrual period _____

Date most recent menstruation began _____

Usual length of menstrual period _____ days

Date of last Pap smear _____

Have you ever had an abnormal Pap smear? Yes No

If yes, give date and describe _____

Have you stopped having menstrual periods? Yes No If yes, when _____

Do you have regular problems with:

Irregular, painful, or heavy menstrual periods Yes No

Bleeding between periods or after menopause Yes No

Vaginal discharge, pain or itching Yes No

Hot flashes Yes No

Pain or lumps in breasts Yes No

If you see a gynecologist for your annual exams, please list their name/phone: _____

Please return to:

Daryl R. Dutter, M.D., Inc.

Kent A. Hufford, M.D.

J. Jeffrey Daley, M.D.

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