RIPON Family Physicians

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 – 6:00PM Monday - Thursday and 7AM - 4PM on Friday. Phone hours are from 8-12 and 1-5, Monday - Thursday, and from 8-12 and 1-4 on 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 48-72 hours.

8. Visit our website for more information: www.RiponDocs.com

9. Our doctors request that prior to a new patient's first appointment, past medical records be transferred to our office in order to effectively manage your care.

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 appointment and lab reminders, test results, 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 # _____

RIPON Family Physicians

Medical Records Release Form

Please fax my 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

Please fax the records OR send on disk.

PRINT Patient's Full Name: _____

_____ _____ _____
Date of Birth Phone Number Medical Record #, if known

_____
Address City State & Zip

SPECIFIC REQUEST:

✓ **Chart Summary, Problem List, Surgical History, Current Medications/Allergies**
✓ Immunization Record
✓ Most recent labs
✓ Colonoscopy/Endoscopy + pathology (adults)
✓ Most recent Pap smear pathology (women)
✓ Most recent Mammogram (women)

☐ Drug/Alcohol/Substance abuse records
☐ Psychiatric/Mental health records
☐ HIV/STD results
☐ Genetic Information

OTHER _____

Purpose: At the request of the individual.
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.
The covered entity may not condition treatment or payment upon whether the individual signs the authorization.

_____ _____
Signature Relationship to patient, (if different)

_____
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	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	Kidney disease/stones	☐ Yes	☐ No
Chronic diarrhea/IBS	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Lung disease/pneumonia	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sexually transmitted disease	☐ Yes	☐ No
If yes, what age?_____			Sleep apnea	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No	Venereal disease/Syphilis	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Thyroid disease/Goiter	☐ Yes	☐ No
Heartburn/Acid Reflux	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Ulcers (stomach or intestinal)	☐ Yes	☐ 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	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Breast Cancer	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Depression	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Diabetes	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Heart Disease	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
High Blood Pressure	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
High Cholesterol	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Kidney Disease	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Rheumatoid Arthritis	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Strokes	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Thyroid Disorder	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Other_____	☐ Yes	☐ No	_____	☐ Living	☐ 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?**
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ 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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