FAMILY PRACTICE ASSOCIATES, P.C.

433 Summit Blvd, #201 ♦ Broomfield, CO 80021

PATIENT INFORMATION

Last: ______________________________ First: _______________________ MI: ___ Nick Name: _________________

Date of Birth: _________________ ☐ Male ☐ Female SSN: __________________ Marital Status: _________________

Address: ____ City: _____________________ State: ____ Zip: ________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone: _____________________

Email:____ Veteran: ☐ Yes ☐ No Student: ☐ Yes ☐ No

Employer: _____________________________________ Occupation: ____

Please select a Primary Care Provider: ☐ Pamela Abrams, MD ☐ Laura Bland, PA-C

☐ Shannon Christopher, NP ☐ Reed Fischer, PA-C

How did you hear about us? ____

EMERGENCY CONTACT INFORMATION

Emergency Contact: ____ Relationship:_________________________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone: _____________________

ACCOUNT INFORMATION

The GUARANTOR shall be the **responsible party** for payment on the account. ☐ Self ☐ Other (please complete)

Guarantor: ____ Date of Birth: _____________ Sex: ☐ Male ☐ Female

SSN: ________________ Relationship to the patient: ________________ Email:_________________________________

Address: ____ City: _____________________ State: ____ Zip: ________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone: _____________________

Employer: _____________________________________ Occupation: ____

INSURANCE INFORMATION

The patient's insurance card must be presented at the time of your appointment for each visit. Insurance won't be billed until a copy of the card is received. **COPAYS are due at the appointment.** Failure to pay the copay will result in a $10 fee. Self-Pay patients and out-of-network patients are required to pay for the visit in full at the time of service. The patient authorizes Family Practice Associates to release information to the insurance company in order for current and future claims to be processed. Patients **18 years and older** will be responsible for the account unless we received signed notification from your responsible party.

____ ____________________________________

Signature of Patient OR Responsible Party (relationship) Date

Please read and sign our HIPAA, financial policy and privacy practices on the reverse side of the form.

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Patient: ___________________________________

Date of Birth: _______________________________

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

AUTHORIZATION: I authorize Family Practice Associates to use and/or disclose certain Protected Health Information (PHI) about me to the following individuals. (Please print full name.)

☐ None

Spouse: _______________________________ Family Member: _________________________________
Name and relationship.

Other: _________________________________ Other: ____
Name and relationship. *Name and relationship.*

This authorization includes the release of my *complete* medical record for *past, present and future* periods unless otherwise specified here: From ___________________ To _____________________

Your initials are required to withhold the following information:

___ Alcohol/Drug Abuse Treatment ___ Communicable Diseases ___Mental Health Records ___ Other: ________________

I understand that the information used or disclosed may be subject to **re-disclosure** by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. The medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I direct. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I may **revoke** this authorization at any time by notifying FAMILY PRACTICE ASSOCIATES, in writing, of my desire to revoke it. The notice will not apply to actions taken by the requesting person/entity prior to the date FAMILY PRACTICE ASSOCIATES receives the request. This authorization is automatically in force for **3 years or until** (date) _____________________, at which time this authorization expires.

____ ___________________________________

Signature of Patient OR Personal Representative (Relationship) Date

REQUIRES PATIENT SIGNATURE:

I acknowledge that I have received a copy of the **NOTICE OF PRIVACY PRACTICES** regarding my health information.

____ ___________________________________

Signature of Patient OR Personal Representative (Relationship) Date

I acknowledge that I have received a copy of the **NOTICE OF OFFICE AND FINANCIAL POLICIES**.

____ ___________________________________

Signature of Patient OR Personal Representative (Relationship) Date

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As part of our electronic health record standard, would you be willing to state your race and ethnicity? This is an important part of your medical history. Some medical conditions are more prevalent in certain races, such as diabetes, hypertension and cancer.

NAME: ____ **DATE OF BIRTH:** _______________________

RACE: please check only one

- ☐ Native American Indian / Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Unreported / Refused to Report

ETHNICITY: please check only one

- ☐ Hispanic or Latino
- ☐ Non-Hispanic
- ☐ Decline to Specify
- ☐ Unknown / Not Reported
- ☐ Refused to Report

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NEW PATIENT INTAKE FORM – Pediatric (0-5 years of age)

Child's Name: ____
Date of Birth: _____________________ **Age:** _____________
Your Name: ____
Relationship to child: __________________________________

CHILD'S PAST MEDICAL HISTORY:

Where was your child born? _____________________________
Is the child yours by: __birth __adoption __stepchild __other
Pregnancy complications: ________________________________
Delivered by: ____C-section ____vaginal
Was your child premature? _______________________________
Birth weight: ___________________ Length: ______________

INFANCY/CHILDHOOD/ADOLESCENCE:

Asthma or reactive airway disease _______________________
Wheezing, bronchitis, pneumonia ________________________
Seasonal allergies ____________________________________
Food allergies _______________________________________
Recurrent ear infections ________________________________
Urinary tract infections ________________________________
Genetic syndromes ____________________________________
Seizures ____
Anemia ____
Broken bones ____
Mentally challenged or learning disabilities _________________
Depression / anxiety ___________________________________
Other chronic medical conditions __________________________
____
Has your child ever been hospitalized? ____ Yes ____ No
Explain: ____
Any previous surgeries or procedures? ____Yes ____No
Explain: ____
List any other physicians your child is currently seeing and the reason: ____
____

MEDICATIONS: *(*List current medications and dose)
____
____

ALLERGIES: (medicine / vaccines – list and describe reaction)
____

IMMUNIZATIONS: __Dtap __MMR __Polio __Varicella B __Hep A __Hep B __ HIB __Rotavirus __Influenza __Prevnar
Please submit a copy of your child's immunization record.

DEVELOPMENTAL / NUTRITION:

At what age did your child?
____sit alone ____walk alone ____say words ____toilet train
Was your child breast fed? ________ How long? ___________
Has your child had any unusual feeding / dietary problems?
Explain: ____
Are your child's immunizations up-to-date? _________________

Signature of Guardian__________________________ Date_________
Signature of Provider___________________________ Date_________

SOCIAL HISTORY:

Number of persons who lives in the household with the child?
_______ guardians ______siblings
Child's parents: ___married ___unmarried ___divorced ___other
Does your child go to daycare or is cared for by babysitter, family, friend? ____
Do any household members smoke? ____ Yes ____ No
How many hours per day does your child spend:
Watching tv ____ computer____ video games ____
Child's school name: ________________________ Grade_____
Any concerns regarding peer or teacher relationships? ________
Sports / Exercise: Type __________________________________
How often? ________________ How long? _____________

FAMILY HISTORY:

Do any family members have any of the following conditions?

Condition	mother	father	sibling	grandparents
Asthma	______	______	______	__________
Anemia	______	______	______	__________
Blood disorder	______	______	______	__________
Cancer	______	______	______	__________
Heart problems	______	______	______	__________
High blood pressure	______	______	______	__________
Stroke	______	______	______	__________
Diabetes	______	______	______	__________
Thyroid disease	______	______	______	__________
Kidney disease	______	______	______	__________
Seizure	______	______	______	__________
Migraines	______	______	______	__________
Depression/anxiety	______	______	______	__________
Alcoholism/drugs	______	______	______	__________
ADD/ADHD	______	______	______	__________

Please explain all positives: ______________________
____
____

REVIEW OF SYSTEMS: *(Circle all that apply)*

Constitutional
fever, chills, fatigue, unexplained weight loss, excessive thirst

Ears, nose & throat
cough, short of breath, mouth-breathing, snoring, ear pain, runny nose

Respiratory
cough, wheezing, chest tightness

Musculoskeletal
muscle pain, weakness, joint pain, swelling

Other (eye, skin, blood)
blurred vision, squinting, eye drainage, rashes, abnormal moles

Gastrointestinal
nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain

Cardiovascular
chest pain, palpitations, tires easily with exertion, fainting

Genitourinary
frequent urination, burning, bedwetting, frequent accidents

Neurologic
headaches, seizures, clumsiness, milestone delay

Psychiatric/emotional
anxiety/stress, depression, sleep problems, anger concern, concerns with attention, impulse