

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 Jeffrey Mandl, NP

How did you hear about us? Google Ad Facebook Ad Mailing Friend/Referral Name _____

Insurance Company Other _____

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

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	Gastrointestinal nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain
Ears, nose & throat cough, short of breath, mouth-breathing, snoring, ear pain, runny nose	Cardiovascular chest pain, palpitations, tires easily with exertion, fainting
Respiratory cough, wheezing, chest tightness	Genitourinary frequent urination, burning, bedwetting, frequent accidents
Musculoskeletal muscle pain, weakness, joint pain, swelling	Neurologic headaches, seizures, clumsiness, milestone delay
Other (eye, skin, blood) blurred vision, squinting, eye drainage, rashes, abnormal moles	Psychiatric/emotional anxiety/stress, depression, sleep problems, anger concern, concerns with attention, impulse