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: ____

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.

X____ ____________________________________

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.

X____ _____________________________________

Signature of Patient OR Personal Representative (Relationship) Date

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

X____ _____________________________________

Signature of Patient OR Personal Representative (Relationship) Date

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

X____ _____________________________________

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 (13-17 years of age)

Name: ______________________________________ Name you go by: ________________ Date: ______________

Date of Birth: ______/______/_______ Age: _________ ☐ Male ☐ Female

Emergency Contact: ____ Phone:___________________________
(name and relationship)

Pets: ______________________________ Hobbies: ____

CURRENT HEALTH CONCERNS:

List in order of importance the health concerns that you would like to address today?

1. ___________________________________ 4. ________________________________
2. ___________________________________ 5. ________________________________
3. ___________________________________ 6. ________________________________

What, if any, treatments have you tried for these conditions and what were the results? ______________________

____

____

ALLERGIES: *Are you allergic to any medications, herbs, foods, animals or any other substances not mentioned?*

Substance: Reaction:

____________________________ ____

____________________________ ____

____________________________ ____

____________________________ ____

CURRENT MEDICATIONS:

Name of Drug: Reason taking: Dose: How long:

_______________________ ____________________________________ _____________ ___________

_______________________ ____________________________________ _____________ ___________

_______________________ ____________________________________ _____________ ___________

_______________________ ____________________________________ _____________ ___________

Vitamins, minerals and herbal supplements you are taking:

Name: Reason taking: Dose: How long:

_______________________ ____________________________________ _____________ ___________

_______________________ ____________________________________ _____________ ___________

_______________________ ____________________________________ _____________ ___________

FAMILY HISTORY:

	Mother	Father	Brother(s)	Sister(s)
Age (if living)				
Health (good/average)				
Deceased age				

Condition	Mother	Father	Siblings
Allergies			
Alcohol/Drug Abuse			
Anemia			
Arthritis (OA or RA)			
Autoimmune			
Alzheimer's			
Cancer (specify kind)			
Diabetes			
Epilepsy / Seizures			
Hepatitis			
Kidney Disease			
Heart Disease			
High Blood Pressure			
Stroke			
Mental Illness			
Obesity			
Thyroid Condition			
Other			

IMMUNIZATIONS:

☐ Tdap ☐ Hepatitis A ☐ Hepatitis B ☐ Varicella (Chicken Pox) ☐ Gardasil (HPV) ☐ Meningococcal

PAST MEDICAL HISTORY:

Childhood Illnesses:

☐ Chicken Pox ☐ Mumps ☐ Rubella ☐ Whooping cough ☐ Mono
☐ Measles ☐ Tuberculosis ☐ Hepatitis ☐ Other ___________________________

Hospitalizations, surgeries, motor vehicle accidents

____ *year* ____________
____ *year* ____________
____ *year* ____________
____ *year* ____________

MEDICAL CONDITIONS:

Circle (C) if currently experiencing condition or (P) if you have previously experienced condition.

C P Allergies
C P Anemia
C P Asthma
C P Autoimmune
C P Cancer
C P Canker Sores
C P Chronic Fatigue
C P Chronic Infections
C P Depression/Anxiety
C P Diabetes
C P Ear Infections
C P Eating Disorder
C P Eczema
C P Fracture
C P Glaucoma
C P Gonorrhea
C P Heart Disease
C P Herpes
C P Hepatitis
C P High Blood Pressure
C P HIV/AIDS or ARC
C P Hypertension
C P Irritable Bowel
C P Joint Problems
C P Lung Disease
C P Mononucleosis
C P Pneumonia
C P Seizures
C P Substance Abuse
C P Stroke
C P Syphilis
C P Tonsillitis
C P Ulcers
C P Venereal Disease
C P Weight Change

*Other Medical Conditions:*____

____

X-Rays, CAT Scans or Other diagnostic studies: ____

____

Accident / Injuries / Transfusions (Type, Date and Important Details): ________________________________

____

____

LIFESTYLE / ENVIRONMENTAL FACTORS:

Do you consume any of the following at least once a week?

____ Antacids	____ Artifical sweeteners	____ Alcohol	____ Carbonated drinks
____ Coffee	____ Distilled water	____ Fast Foods	____ Fried foods
____ Laxatives	____ Luncheon meat	____ Margarine	____ Salt (in excess)
____ Tea	____ Tobacco	____ Sweets / Candy	

Do you have any dietary restrictions? Explain: ____

____

____

Are you under excess stress? Explain: ____

____

How is your energy level? Rate on a scale of 1 to 10 (1=very low, 10=excellent): ___________________

Do you exercise regularly (include frequency, duration and type)? ____

____

What is your current weight? ___________ Maximum? __________ Ideal? _____________

Have you ever been physically, sexually, and/or emotionally abused? Explain: _______________________________

____

____

Do you use any recreational drugs (include type and frequency)? ____

____

____

How old is your residence? __________________ Type of heating? _______________

Type of flooring (hardwood, linoleum, carpets, rugs, etc.): ____

Any pets? __________ What kind? ____

Please use the space below to include any further information regarding your personal health history, family history, past medical history or lifestyle / environmental factors that may be of relevance to your service provider:

____

____

____

REVIEW OF SYSTEMS:

Please check off any conditions you currently have.

General:
____ Poor appetite
____ Sleep difficulties
____ Heat/cold intolerance
____ Fever / chills
____ Fatigue / weakness
____ Significant weight change

Respiratory system:
____ Chronic cough
____ Sputum / phlegm
____ Breathing noises (e.g. wheezing)
____ Shortness of breath
____ (difficulty breathing)
____ Coughing up blood
____ Other _______________

Heart and circulation:
____ Murmurs
____ Palpitations
____ Varicose Veins
____ Calf Pain
____ Swelling of ankles / feet
____ Other _______________

Musculoskeletal:
____ Broken bones
____ Muscle cramps
____ Joint swelling / pain / stiffness
____ Weakness
____ Bone pain
____ Back pain
____ Osteoporosis
____ Rheumatoid arthritis
____ Other _________________

Head:
_____ Headaches
_____ Eye problems
_____ Ear infections
_____ Earaches
_____ Nasal congestion
_____ Dizziness
_____ Hearing problems
_____ Ringing/buzzing in ears
_____ Nose bleeds
_____ Frequent nasal discharge
_____ Other _______________

Urinary system:
_____ Urinary frequency
_____ Sense of urgency
_____ Frequency at night
_____ Pain
_____ Dribbling
_____ Blood in urine
_____ Cloudiness
_____ Difficulty passing urine
_____ Frequent infections
_____ Change in color

Nervous system:
_____ Fainting
_____ Numbness / tingling
_____ Loss of balance
_____ Paralysis
_____ Tremors
Other _____________

Skin:
____ Rash / hives
____ Easy bruising
____ Lumps
____ Hair problems / changes
____ Jaundice
____ Itching

Mouth, throat & neck:
____ Frequent sore throats
____ Sore tongue/mouth/gums
____ Chronic bad breath
____ Swollen glands
____ Dental Cavities
____ Other ________________

Abdominal & Gastrointestinal system:
____ Change in appetite
____ Change in thirst
____ Nausea / Vomiting
____ Blood in stool
____ Tarry black stool
____ Belching / flatus
____ Heartburn
____ Indigestion
____ Bloating
____ Diarrhea
____ Constipation
____ Hernias
____ Food allergies / intolerances
____ Abdominal pain
____ Hepatitis
____ Change in bowel habit
____ Change in stool color

FEMALE:
Age of first period? ____________
Length of full cycle? ______________
____ Premenstrual symptoms
____ Painful periods
____ Infertility
____ Frequent vaginal infections
____ Discharge
____ Breast lumps / tenderness

Female continued:
_____ Pregnancies # ________
_____ Miscarriages #_______
_____ Abortions #________
_____ Abnormal Pap tests
_____ Sexually transmitted diseases
_____ Birth control
type? ________________
_____ Other gynecological concerns
_____ Are you sexually active with
men__ women__ both __

MALE:
____ Sexually transmitted diseases
____ Discharge
____ Rashes
____ Pain in genitals
____ Varicose veins in scrotum
____ Difficulty starting / stopping urine flow?
____ Are you sexually active with
men__ women__ both __

Is there any information about your child's health that you would like to add?___________________________________

____

How did you hear about FPA? ____