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.

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.

FAMILY PRACTICE ASSOCIATES, P.C.

433 Summit Blvd, #201 ♦ Broomfield, CO 80021

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 OFFICE AND FINANCIAL POLICIES**.

X_____ _____

Signature of Patient OR Personal Representative (Relationship) Date

FAMILY PRACTICE ASSOCIATES, P.C.

433 Summit Blvd, #201 ♦ Broomfield, CO 80021

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

FAMILY PRACTICE ASSOCIATES, P.C.
433 Summit Blvd, #201
Broomfield, CO 80021

NEW PATIENT INTAKE FORM – Pediatric (6-12 years of age)

Patient's Name:_____ Date: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Female ☐ Male

Mother's name: _____ Father's name:_____

Legal guardian name (if applicable): _____

Does your child have a contagious disease at this time? ☐ Yes ☐ No If Yes, what?_____

Medical Concerns: - What are the top concerns that you would like addressed?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Previous Illnesses:

☐ Tonsillitis. Approximate number _____ ☐ Measles ☐ Rheumatic fever
☐ Ear Infections. Approximate number _____ ☐ German Measles ☐ Other: _____

Other Medical Conditions:

_____

_____

Has your child ever had the following tests:

Electroencephalogram (EEG): _____ Yes _____ No
Psychological evaluation: _____ Yes _____ No
Hearing tests, Speech/Language tests: _____ Yes _____ No

Hospitalizations / Surgeries / Injuries: What hospitalizations, surgeries or injuries has your child had?

_____

_____

Immunizations:

☐ Polio ☐ Dtap ☐ Tdap ☐ Hepatitis A ☐ Hepatitis B ☐ HIB
☐ Chicken Pox ☐ Influenza ☐ Measles / Mumps / Rubella ☐ Pneumococcal PCV13
Any adverse reactions? ☐ Yes ☐ No If Yes, what? _____

Allergies:

Is your child hypersensitive or allergic to any drugs? ☐ Yes ☐ No
Any food? ☐ Yes ☐ No Anything environmental? ☐ Yes ☐ No
Breast fed? _____ How long? _____ Formula? _____ Milk/Soy? _____

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list any **prescriptions medications, over the counter medications, vitamins or other supplements** your child is taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

REVIEW OF SYSTEMS

Y = a condition now **P** = a condition in the past **N** = never had

MENTAL / EMOTIONAL:				**EARS:**				**URINARY:**			
Mood Swings	Y	P	N	Earaches	Y	P	N	Frequent urinations	Y	P	N
Irritability	Y	P	N	Impaired hearing	Y	P	N	Bedwetting	Y	P	N
Hyperactivity	Y	P	N								
Introvert/extrovert	Y	P	N	**EYES:**				**RESPIRATORY:**			
Nightmares	Y	P	N	Glasses or contacts	Y	P	N	Cough	Y	P	N
Anxiety/nervousness	Y	P	N	Eye pain / strain	Y	P	N	Asthma	Y	P	N
Cries easily	Y	P	N	Tearing or dryness	Y	P	N	Wheezing	Y	P	N
Unusual fears	Y	P	N					Bronchitis	Y	P	N
Sleep problems	Y	P	N	**NOSE AND SINUSES:**							
Motion/car sickness	Y	P	N	Frequent colds	Y	P	N	**CARDIOVASCULAR:**			
				Stuffiness	Y	P	N	Heart disease	Y	P	N
ENDOCRINE:				Sinus problems	Y	P	N	Murmurs	Y	P	N
Heat/cold intolerance	Y	P	N	Nose bleeds	Y	P	N				
High blood sugar	Y	P	N	Hayfever	Y	P	N	**MUSCULOSKETETAL:**			
Excessive hunger	Y	P	N	Loss of smell	Y	P	N	Joint pain / stiffness	Y	P	N
								Broken bones	Y	P	N
SKIN:				**MOUTH AND THROAT:**				Muscle spasms/cramps	Y	P	N
Rashes	Y	P	N	Frequent sore throat	Y	P	N				
Acne, Boils	Y	P	N	Breath odor	Y	P	N	**BLOOD/PERIPHERAL VASCULAR:**			
Eczema, Hives	Y	P	N	Canker sores	Y	P	N	Anemia	Y	P	N
Itching	Y	P	N					Easy bleeding/bruising	Y	P	N
				GASTROINTESTINAL:							
HEAD:				Belching / passing gas	Y	P	N				
Headaches	Y	P	N	Constipation	Y	P	N				
Dizzy spells	Y	P	N	Bowel movements	Y	P	N				
Head Injury	Y	P	N	Stomach aches	Y	P	N				
High fevers	Y	P	N	Diarrhea	Y	P	N				
				How often? _____							

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			

SOCIAL HISTORY:

Grades earned: _____

Special Needs? ☐ Yes ☐ No

Exercise / Sports: _____ hours per day

TV / Computer Games / Screen Time: _____ hours per day

Sleep Issues? ☐ Yes ☐ No

Parents marital status? ☐ Married ☐ Divorced Parent deceased? _____

Smoking at home? ☐ Yes ☐ No

Pets at home? ☐ Yes ☐ No

Firearms at home? ☐ Yes ☐ No

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

_____

_____