Douglas Family Medicine, PC
1189 S Perry St, St 230
Castle Rock, CO 80104
P: 303-688-3434 F: 303-688-4454
info@douglasfamilymedicine.com
www.douglasfamilymedicine.com

PATIENT INFORMATION

PATIENT NAME: LAST_____ FIRST_____ TODAY'S DATE _____

SOCIAL SECURITY NUMBER_____-_____-_____ DATE OF BIRTH_____ AGE_____ SEX M F

ADDRESS_____ APT#_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL/WORK_____ EMAIL_____

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

PRIMARY CARE DOCTOR_____ PHONE_____

PREFERRED PHARMACY_____ PHONE_____

MAIL ORDER PHARMACY_____ PHONE_____

EMERGENCY CONTACT_____ PHONE_____

EMERGENCY CONTACT RELATIONSHIP _____

INSURANCE POLICY HOLDER

NAME_____ RELATIONSHIP_____

ADDRESS _____

PHONE_____ SOCIAL SECURITY NUMBER_____-_____-_____ DATE OF BIRTH _____

PRIMARY INSURANCE

PRIMARY INSURANCE COMPANY _____

POLICY/ID #_____ GROUP # _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME _____

POLICY/ID #_____ GROUP # _____

HOW DID YOU HEAR ABOUT US?

REFERRING PHYSICIAN_____ FRIEND_____

INTERNET_____ INSURANCE OTHER _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I acknowledge that I have read the HIPAA Notice of Privacy Practices and understand my rights concerning uses and disclosures of Protected Health Information.

PATIENT AND/OR INSURED SIGNATURE _____ DATE _____

VOICE MAIL AUTHORIZATION

Douglas Family Medicine is committed to insuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996. (HIPPA)

At times our office may need to communicate with you outside of the office. We would like to contact you in the most convenient manner while still guarding your privacy. If you would like us to leave a voice mail message, or a message with someone other than the patient please check and sign below.

- ☐ Clinical Information
- ☐ Financial Information

PATIENT NAME_____ DATE_____

SIGNATURE_____

FINANCIAL POLICY

We, at Douglas Family Medicine, are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

If you are self paying, full payment for service is due at the time the services are rendered.
Insurance CO-PAYS are due at the time of service. A $5.00 billing fee will be added if we have to bill you for a co-payment amount.

As a courtesy, we are happy to submit your insurance claim for you. However, please be aware that an insurance contract is between YOU and your INSURANCE COMPANY. We will make our best effort to collect from them, but if we are not successful, YOU are responsible for the unpaid balance. It is also the patient's responsibility to understand the insurance contract, including services covered, deductibles, co-pays and co-insurance included in your plan.

Your account is considered late if payment is not received 30 days past the statement date. Returned checks and balances older than 30 days are subject to a $25 late fee. All accounts 60 days past due will be sent to collections. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact our office to arrange a payment plan.

If you have any questions concerning our financial policy, please don't hesitate to ask. We are here to help and look forward to continuing a good patient relationship with you.

PATIENT AND/OR INSURED SIGNATURE_____ DATE _____

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Medical History Form

Patient Name_____ Today's Date_____
Medical History (examples include Diabetes, High blood pressure, Cancer)
_____ _____
_____ _____
Allergies (please list reaction type)
☐ Penicillin ☐Sulfa ☐ Latex ☐ Tape ☐ Other _____
☐ Rash/Hives ☐ Shortness of breath ☐ Stomach pains ☐ Anaphylactic ☐ Other _____

Medications currently taking (please include herbals and over the counter medications)
_____ _____
_____ _____

Family History ☐ Diabetes ☐ Heart Disease ☐ Kidney Disease ☐ Cancer
☐ Other _____

Do you use tobacco? ☐ Yes ☐ No If so, how much? _____
Have you ever used tobacco? ☐ Yes ☐ No when did you quit? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____
Do you use marijuana? ☐ Yes ☐ No
Do you use recreational drugs? ☐ Yes ☐ No

Please check any other personal medical history:
Eyes, Ears, Nose and Throat
☐ Eyeglasses/Contacts ☐ Dizzy Spells ☐ Conjunctivitis ☐ Sinus Infection ☐ Nose bleeds
Head and Neck
☐ Neck Pain ☐ Headache ☐ Migraine
Extremities
☐ Numbness/Tingling ☐ Ulcers ☐ Varicose Veins ☐ Discoloration
Musculoskeletal
☐ Arthritis ☐ Fibromyalgia ☐ Joint Pain ☐ Back Pain ☐ Tremors ☐ Swelling ☐ Muscular Weakness
Neurologic
☐ Anxiety ☐ Seizures ☐ Depression
Cardiovascular
☐ Chest Pain ☐ Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐ Rheumatic Fever
☐ Heart Murmurs
Respiratory
☐ Asthma ☐ Emphysema ☐ Shortness of Breath
Endocrine
☐ Thyroid Disease ☐ Diabetes ☐ Gout ☐ Anemia ☐ Blood Clotting Problems
Gastrointestinal
☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Increased Appetite
Genitourinary
☐ Increased Urination Frequency ☐ Kidney Stones ☐ Nephropathy