

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.

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.

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

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

Name: _____ DOB: _____ Date: _____

Please check any of the following medical problems you have had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis or Joint Pain | <input type="checkbox"/> Abnormal Pap Smear |
| <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Gout | <input type="checkbox"/> Abnormal Mammogram |
| <input type="checkbox"/> Glasses / Contacts | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Breast Lump |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure | ___ # of Pregnancies |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> TIA | ___ Live Births |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | ___ Miscarriages |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | ___ Abortions |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Anxiety / Panic Attacks | Have you even been exposed to or do you have a family member with ... |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Hepatitis |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> TB |
| | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mental Illness | |
| | <input type="checkbox"/> Color Polyp | <input type="checkbox"/> Diabetes | |
| | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Thyroid Disease | |
| | | <input type="checkbox"/> Sexually Transmitted Diseases | |

Other **medical conditions not listed above:**

List **all surgeries** you have had:

List **all medication** allergies:

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

List all **medications, vitamins, and supplements** you are currently taking:

List all **health care providers** you have seen in the past or are currently seeing:

1. _____

2. _____

3. _____

1. _____

2. _____

3. _____

<p>4. _____ _____</p> <p>5. _____ _____</p> <p>6. _____ _____</p> <p>7. _____ _____</p>	<p>4. _____ _____</p> <p>5. _____ _____</p> <p>6. _____ _____</p> <p>7. _____ _____</p>
---	---

Immunizations: Tdap Hepatitis A Hepatitis B Pneumovax Zoster Influenza

Please list the **last year** in which you have had any of the following:

Tdap _____ Pneumonia shot _____ Hepatitis B series _____ Zoster _____
 Flu shot _____ PPD (TB Test) _____ Measles, Mumps, Rubella (MMR) _____

NP Adult Pg 1 of 3 -- Rev: 72517

Please list the last year in which you have had any of the following:

Physical Exam _____	Cholesterol _____	Sigmoidoscopy _____
Pap Smear _____	Stress Test _____	Colonoscopy _____
Mammogram _____	Bone Density _____	Stool Cards for Colon Cancer _____
Testicular Exam _____	Eye Exam _____	
Rectal/Prostate Exam _____	Dental Visit _____	

Please list your use of tobacco products:

None Cigarettes Smokeless Tobacco Pipe Cigars Marijuana
 How much do you or did you smoke per day? _____ For how many years? _____
 Do you wish to quit? Now Soon Eventually Never
 Have you quit? Yes No If so, when? _____
 Have you used illicit drugs (heroin, cocaine, LSD, etc.)? Yes No

How much alcohol do you drink weekly on average? _____

Do you have a problem with alcohol? Yes No

How much caffeine do you drink daily (include coffee, tea, cola)? _____

Are you sexually active? Yes No Are your partners? Male Female Both

Do you use contraception?

None Rhythm Condoms Pill Vasectomy IUD Diaphragm Tubal Ligation

Do you practice safe sex? Never Sometimes Always

Have you ever had a blood transfusion? Yes No If yes, what year? _____

Have you recently traveled outside the U.S.? Yes No Where? _____

Marital Status: Single Married Separated Divorced Widowed Partner

Are you currently... Employed Self-Employed Unemployed Retired
What is or was your occupation? _____

Do you exercise regularly? Yes No
What activity? _____ How often? _____

Please check the following **behaviors that you follow**:

- | | | |
|--|--|---|
| <input type="checkbox"/> Low carbohydrate diet | <input type="checkbox"/> Wear seatbelt | <input type="checkbox"/> Fire Extinguisher in house |
| <input type="checkbox"/> Exercise more than 3 times per week | <input type="checkbox"/> Wear helmet while riding bike / motorcycle | <input type="checkbox"/> Smoke detector in house |
| <input type="checkbox"/> Perform self-breast exam regularly | <input type="checkbox"/> Living Will or Advanced Directive | <input type="checkbox"/> Gun in house |
| <input type="checkbox"/> Perform self-testicular exam | <input type="checkbox"/> Frequent exposure to animals (dogs, cats, etc.) | <input type="checkbox"/> Gun secured by lock |

Please check if there is a history of any of the following **diseases** in your family:

- | | | | | |
|--|---|---------------------------------------|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Prostate Cancer | |

Please fill in the following **family history of medical problems**:

Father: _____ Mother: _____
Brother(s): _____ Son(s): _____
Sister(s): _____ Daughter(s): _____

NP Adult Pg 2 of 3 -- Rev: 72517

REVIEW OF SYSTEMS:

Current health symptoms. Please complete all questions.

- | | | | | | |
|-----|--|--------------------------|-----|--------------------------|----|
| 1. | Have you had a recent weight gain or loss that worries you? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. | Have you had any unexplained fevers or night sweats ? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. | Do you have sinus or nasal allergy symptoms that affect your quality of life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. | Do you have any vision or hearing problems that are bothersome? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. | Are you experiencing chest pains or irregular beats that worry you? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. | Do you have unusual shortness of breath or a persistent cough ? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. | Do you have leg swelling that is recurrent or bothersome? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. | Do you experience wheezing when you breathe? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. | Do you have sleep problems that interfere with your quality of life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. | Have you been told that you snore and stop breathing during sleep? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. | Do you have constipation, diarrhea, stomach pain or other problems with digestion that interfere with your quality of life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 12. | Have your bowel movement patterns changed in recent months? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 13. | Do you have problems with urination that affects your quality of life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 14. | Do you have problems with sexual function that affects your quality of life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 15. | Do you have joint or back problems that affect your quality of life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 16. | Do you have leg pain, numbness or weakness that limits how fast or how far you can walk? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 17. | Do you have headaches that affect your ability to function? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 18. | Have you had an unexpected fall with injury in the past year? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 19. | Do you have poor balance or fear of falling ? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 20. | Do you have little pleasure in doing things? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 21. | Do you feel down, depressed, or hopeless ? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 22. | Are you concerned about anxiety or stress in your life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 23. | Are you concerned about your memory ? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 24. | Have you noticed unusual bruising or bleeding ? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 25. | Do you have unusual skin lesions that concern you? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Comments: _____

Note: Evaluation of these concerns is not usually part of the annual wellness or preventative exam. It is likely that your doctor will need to schedule an additional appointment to follow up on these problems.

Patient Signature _____ Date _____

Physician Signature _____ Date _____