

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.

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 OFFICE AND 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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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:

- Mood Swings Y P N
- Irritability Y P N
- Hyperactivity Y P N
- Introvert/extrovert Y P N
- Nightmares Y P N
- Anxiety/nervousness Y P N
- Cries easily Y P N
- Unusual fears Y P N
- Sleep problems Y P N
- Motion/car sickness Y P N

ENDOCRINE:

- Heat/cold intolerance Y P N
- High blood sugar Y P N
- Excessive hunger Y P N

SKIN:

- Rashes Y P N
- Acne, Boils Y P N
- Eczema, Hives Y P N
- Itching Y P N

HEAD:

- Headaches Y P N
- Dizzy spells Y P N
- Head Injury Y P N
- High fevers Y P N

EARS:

- Earaches Y P N
- Impaired hearing Y P N

EYES:

- Glasses or contacts Y P N
- Eye pain / strain Y P N
- Tearing or dryness Y P N

NOSE AND SINUSES:

- Frequent colds Y P N
- Stuffiness Y P N
- Sinus problems Y P N
- Nose bleeds Y P N
- Hayfever Y P N
- Loss of smell Y P N

MOUTH AND THROAT:

- Frequent sore throat Y P N
- Breath odor Y P N
- Canker sores Y P N

GASTROINTESTINAL:

- Belching / passing gas Y P N
- Constipation Y P N
- Bowel movements Y P N
- Stomach aches Y P N
- Diarrhea Y P N

How often? _____

URINARY:

- Frequent urinations Y P N
- Bedwetting Y P N

RESPIRATORY:

- Cough Y P N
- Asthma Y P N
- Wheezing Y P N
- Bronchitis Y P N

CARDIOVASCULAR:

- Heart disease Y P N
- Murmurs Y P N

MUSCULOSKETETAL:

- Joint pain / stiffness Y P N
- Broken bones Y P N
- Muscle spasms/cramps Y P N

BLOOD/PERIPHERAL VASCULAR:

- Anemia Y P N
- Easy bleeding/bruising Y P N

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?
