

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.

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

433 Summit Blvd, #201
Broomfield, CO 80021

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

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?

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Artificial sweeteners | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Carbonated drinks |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Distilled water | <input type="checkbox"/> Fast Foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Luncheon meat | <input type="checkbox"/> Margarine | <input type="checkbox"/> Salt (in excess) |
| <input type="checkbox"/> Tea | <input type="checkbox"/> Tobacco | <input type="checkbox"/> 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 _____

FEMALE:

- Age of first period? _____
- Length of full cycle? _____
- Premenstrual symptoms
- Painful periods
- Infertility
- Frequent vaginal infections
- Discharge
- Breast lumps / tenderness

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 _____

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 __

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

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? _____