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: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Please select a Primary Care Provider: ☐ Pamela Abrams, MD ☐ Laura Bland, PA-C ☐ Jeffrey Mandl, NP

PARENT/GUARDIAN CONTACT INFORMATION

The person accompanying the minor shall be the **responsible party** for payment on the account.

Parent/Guardian 1: _____ Relationship: _____

Date of Birth: _____ Cell Phone: _____ Other Phone: _____

Address: ☐ Same as above ☐ Other _____

Parent/Guardian 2: _____ Relationship: _____

Date of Birth: _____ Cell Phone: _____ Other Phone: _____

Address: ☐ Same as above ☐ Other _____

INSURANCE PLOICY HOLDER

Full Name: _____ 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

Family Practice ASSOCIATES

433 Summit Boulevard, Suite 201
Broomfield, CO 80021
Telephone: 303-673-9090
Fax: 303-673-9195
www.ourfpa.com

Informed Consent for Telemedicine Services

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver sevices to an individual when he/she is located at a different location or site than I am, and I must be physically located in the state of Colorado when receiving this service through Family Practice Associates
- I understand the potential limitations of telemedicine, and that services will be provided to the best ability of the healthcare provider.
- I understand that Family Practice Associates utilizes the Hippo Health software program to conduct telemedicine services, and I agree to installing this application (app) on my cell phone, computer and/or tablet in order to receive telemedicine.
- I understand that the telemedicine visit will be performed through a two-way video link-up. The healthcare provider will be able to see my image on my cell phone screen, computer monitor or tablet, and the provider will hear my voice. I will be able to hear and see the healthcare provider.
- I understand that technical difficulties may occur before or during the telemedicine session, and that the healthcare provider may conduct the appointment via regular telephone communication if such difficulties interfere with utilizing Hippo Health.
- I understand the the laws that protect privacy and the confidentiality of medical information, including HIPAA, also apply to telemedicine.
- I understand that I will be responsible for any copayments or other financial patient responsibility, and that I am responsible for knowing whether my insurance plan covers telemedicine.
- I understand that by signing this form that I am consenting to receive health care services via telemedicine.

☐ **I agree** ☐ **I decline**

Patient Name _____ Date of Birth _____

Patient Signature _____ Today's Date _____

- OR - Legal Guardian Name _____

Legal Guardian Signature _____ Today's Date _____

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NEW PATIENT INTAKE FORM – Pediatric (13-17 years of age)

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?

____ Antacids	____ Artifical sweeteners	____ Alcohol	____ Carbonated drinks
____ Coffee	____ Distilled water	____ Fast Foods	____ Fried foods
____ Laxatives	____ Luncheon meat	____ Margarine	____ Salt (in excess)
____ Tea	____ Tobacco	____ 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 _____

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 _____

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

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

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 __

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?_____

_____