Burrows Family Practice, Inc.
1377 S. Grand Ave Glendora, CA 91740
Phone (626) 483-3348
Fax (626) 623-7258

Please complete this form to insure your complete medical history is captured for the staff & providers review. Thank you in advance for your cooperation. ☺

Full Name _____**Date**_____
Birth Date _____ **Age** _____

ADVANCE DIRECTIVE/DNR (age 18 or older)

Do you have an advance directive or a DNR (Do not Resuscitate) paperwork in place? □ *Yes* □ *No*
If yes, please provide our office a copy at your earliest if not it is a requirement for our office to provide you paperwork in regards to this matter. Thank you in advance for your cooperation.

DRUG ALLERGIES/ADVERSE REACTION **□ NO DRUG ALLERGIES**

ALLERGY/ADVERSE REACTION NAME	TYPE OF REACTION

MEDICATIONS (PLEASE LIST ALL NAMES, DOSAGE AND TIME PER DAY. Ex: Aspirin 81 mg one a day) **□ No Long Term Medications Taken**

MEDICATION NAME	DOSAGE (mg, units etc)	TIMES PER DAY

If you need more room to list your medications, please write them on a blank sheet of paper with the required information or bring bottles with you to the appointment.

SCREENING AND PREVENTION TESTING HISTORY *Please indicate below the information as requested to the best of your recollection. If you have any medical records to support these testing we would appreciate a copy otherwise, we can do our best to obtain the information. Enter information only applicable to you based on age, sex etc…*

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Colonoscopy Date :	Location	Abnormal Result □ Y □ N
Mammogram Date :	Location:	Abnormal Result □ Y □ N
Pap Smear Date :	Location :	Abnormal Result □ Y □ N
Bone Density :	Location :	Abnormal Result □ Y □ N

VACCINATION HISTORY

Please indicate below to the best of your recollection the last immunization record for the below vaccinations. Please bring proof of immunization record if you have it. □ Patient refuses ALL vaccinations/immunizations

Tetanus Booster (TD) or Tdap	Prevnar (PCV 13)
Influenza (Flu vaccine)	Pneumovax (PPV23)
Zostavax (old shingles)	HPV (Gardasil 9 date of all 3)
Shingrix (new shingles)	MMR (measles, mumps, rubella)
Other vaccines:	

PERSONAL MEDICAL HISTORY *Please check all that apply below:*

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type:_____)			
Depression/Anxiety			
Type 1 Diabetes			
Type 2 Diabetes			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Hypothyroidism/Thyroid disease			
Migraine Headaches			
Renal (kidney) Disease			
Acid Reflux (Gastroesophageal Disease)			
Stroke			
Other:			
Other:			

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SURGICAL HISTORY

Please indicate below all significant surgical history that will be pertinent for us to know. Example would be gallbladder removal (cholecystectomy), total abdominal hysterectomy, partial hysterectomy, vasectomy, knee replacement, breast augmentation/implants etc….

TYPE OF SURGERY (LEFT/RIGHT)	DATE	LOCATION/FACILITY

FAMILY MEDICAL HISTORY □ NO SIGNIFICANT FAMILY HISTORY IS KNOWN □ UNKNOWN/ADOPTED

√ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Brain Cancer	Breast Cancer	Lung Cancer	Colon Cancer	Prostate Cancer	Ovarian Cancer	Emphysema(COPD)	Depression/anxiety	Bipolar Disorder	Diabetes	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Alzheimer Disease	Other:	Other
Mother																					
Father																					
Brother																					
Sister																					
Maternal Grandma																					
Maternal Grandpa																					
Paternal Grandma																					
Paternal Grandpa																					
Child																					

Important information for us to know would be if any of the above family members are deceased due to any of the above conditions? If yes, please indicate who and the cause of death if known please. We apologize in advance for we acknowledge the sensitivity of this information. Thank you

_____

_____

_____

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SOCIAL HISTORY

Tobacco(chew, cigar,pipe,cigarette)	Do you use tobacco products now or in the past? □ Yes □ No Number of years:_____ Number of packs per day:_____ □ Former Smoker Quit Date_____
Nicotine (vape)	□ Never □ Current □ Former
Alcohol	Do you drink alcohol? □ Non-Drinker □ Yes □ Daily, how much? _____ □ Socially, how often? _____ □ Rarely (i.e. special occasions/holidays etc) Type □ Beer □ Wine □ Liquor Former Drinker □ Yes Quit Date_____
Recreational Drugs	□ Never □ Current □ Social/Occasional What drug(s)? _____ □ Former User What drug(s)? _____

Thank you in advance for taking the time to complete our patient history intake form.

Patient Signature_____ Date _____

Provider Signature_____ Date _____

Burrows Family Practice, Inc.

Date: _____ Date of Birth_____

PLEASE PRINT:
Name: _____
Last First Middle
Address Street: _____

City: _____ State: _____ Zip: _____

Race:_____Ethnicity:_____Marital Status:_____ Sex:_____
Preferred Language:_____

Preferred Phone Number ( ) - _____- _____ Home/Cell/Work
Additional Phone Number ( ) - _____- _____ Home/Cell/Work

Email Address: _____

Social Security Number _____ - _____ - _____

Name of Primary Insurance Carrier:_____ Copay_____
Member ID #_____ Group ID #_____

Subscriber Information for Insurance: (If other than the patient).
Name: _____ Relation: _____
Address: _____
Phone Number: ( ) _____ Date of Birth_____

PREFERRED PHARMACY: This information is very important.

_____ _____
Pharmacy Name and Location Pharmacy Phone Number:

EMERGENCY CONTACT
Name:_____Relation:_____
Address:_____
Phone Number: ( )_____Date of Birth_____

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Patient's Name _____ Date of Birth _____

HISTORY AND PHYSICAL

Burrows Family Practice, Inc.

DRUG ALLERGIES

_____
_____
_____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	Father	Mother	Father's Parent's	Mother's Parent's	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

Medical History

☐ Headache	☐ Lactose Intolerance	☐ Depression
☐ Shortness of Breath	☐ Gallbladder Disease	☐ Gout
☐ Heart Palpitations	☐ Prostate Disease	☐ Scarlet Fever
☐ Heart Murmur	☐ Bowel Irregularity	☐ Chronic Rashes
☐ Chest Pain	☐ Incontinence	☐ Rheumatic Fever
☐ Dizziness/Fainting	☐ Sexual/Menstrual Dysfunction	☐ Mumps
☐ Peripheral Vascular Disease	☐ Venereal Disease	☐ Measles
☐ Allergies/ Hay Fever	☐ Frequent Infections	☐ Rubella
☐ Asthma	☐ Hepatitis	☐ Polio
☐ Bronchitis	☐ Anemia	☐ Diphtheria
☐ Pneumonia	☐ Arthritis	☐ Tetanus
☐ Ulcer	☐ Osteoporosis	☐ Other
☐ GI Disorder	☐ Nervousness	☐ Other

WOMEN ONLY: Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

MEN Only: it's common for men to occasionally experience erection difficulties. Is this something that happens to you? ☐ Yes ☐ No
If yes, how often does this occur? ☐ Frequently ☐ Sometimes ☐ Rarely

HABITS

Yes	No		Yes	No		Yes	No	Sleep:
☐	☐	Smoke? Packs Daily _____ How long _____	☐	☐	Coffee: Cups Daily _____	☐	☐	Difficulty Falling Asleep
☐	☐	Interested in stopping?	☐	☐	Other Caffeine _____	☐	☐	Snoring
☐	☐	Exercise? Type: _____ Frequency: _____	☐	☐	Alcohol: Type _____ Amount _____	☐	☐	Daytime Drowsiness
			☐	☐	Diet: Salt intake _____ Fat Intake _____			

Burrows Family Practice, Inc.

AUTHORIZATION TO TREAT

I (and/or the undersigned on behalf of the patient) voluntarily consent to allow Burrows Family Practice and staff to provide such evaluation and/or care and treatments as deemed advisable and necessary.

I understand that although care is reviewed and supervised by BFP physicians, actual care may be rendered by physician extenders (i.e. physician assistants or nurse practitioners).

I understand that should I execute a Durable Power of Attorney for Health Care or other Advance Directive, I will provide an executed copy to my physician. I further understand that I will notify my physician of any changes in the Directive.

I understand that I will be informed about the course of my treatment. Also, I am free to terminate my treatment with BFP at any time.

CONSENT FOR TREATMENT:

I, the undersigned, do hereby authorize and consent to medical treatment which is deemed advisable and is to be rendered under the general or special supervision of our medical staff. This consent will remain in effect from the date of initiation through the duration of my treatment.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature of Patient or Legal Representative Date

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FINANCIAL POLICY

INSURANCE:
Our practice participates in a variety of insurance plans. **It is your responsibility to:**
•BRING IN YOUR INSURANCE CARD TO EVERY OFFICE VISIT.
•CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF THE OFFICE VISIT, IF NOT COLLECTED THERE WILL BE A $25.00 BILLING FEE. COINSURANCE IS BILLED AFTER YOUR INSURANCE COMPANY HAS PAID ITS PORTION OF THE CLAIM.
•PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE FOR ANY MEDICAL CARE NOT COVERED BY YOUR INSURANCE. IF WE CANNOT VERIFY INFORMATION AT TIME OF SERVICE WE WILL TAKE CASH PAYMENT AND REIMBURSE YOU WHEN INSURANCE IS PAID.

SELF PAY PATIENTS: Payment for office visit is due at the time of service.

RETURNED CHECK FEE: You will be charged $25.00 for a returned check from your bank for any reason.
CANCELLED APPOINTMENTS: This office requires a 24-hour notice if you are unable to keep your scheduled appointment. If we do not receive 24-hour notice, you will be charged a no-show fee of $25.00 for missed medical office visits.
REFERRALS: Please allow three (3) business days from the date of requested referral.
LAB FEES: Lab fees for blood work and pathology (including PAP smears) are separate from our office charges and may be billed directly to you by the lab company.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:
I assign directly to **Burrows Family Practice** all medical benefits for services rendered. I understand that I am responsible for all allowable charges whether or not paid by my medical insurance. I hereby authorize the provider to release all my information if necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. In addition, I am responsible for any deductible, copay and coinsurance amounts.

_____ _____
Print Patient Name Date of Birth

_____ _____
Signature of Patient or Legal Representative Date

Burrows Family Practice, Inc.

Notices of Privacy Practices & Acknowledgement Form

By signing below, I acknowledge that Burrows Family Practice has prepared a Notice of Privacy Practices, which informs me how Burrows Family Practice uses and discloses my protected health information and what my privacy rights are in regards to that information. I may obtain a copy of the full, detailed Privacy Notice by asking a Burrows Family Practice front office employee. By signing below, I acknowledge that I am aware Burrows Family Practice has revised their original Notice of Privacy Practices and that I may request a copy of it.

REQUEST FOR CONFIDENTIAL INFORMATION COMMUNICATION

I authorize BFP to leave messages on my answering machine/voice mail pertaining to appointments or payment issues and to send correspondence to the address provided for the insurance holder unless other arrangements are made in advance. I understand that BFP will utilize text messages to notify patients about future appointments and other important notifications if needed. I understand that BFP Providers may use a HIPAA compliant virtual medical scribing service that will assist in documenting the patient visit through secure recorded encounters. This data is encrypted in compliance with federal and state regulations.

PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION WITH OTHER INDIVIDUALS

Individuals to whom Burrows Family Practice may disclose my Personal Health Information for coordination of care purposes. I hereby grant BFP permission to discuss my health information with persons listed below as it relates to my care.

	Name	DOB	Relationship	Phone #
1.				
2.				
3.				

I understand that if I do not list anyone and am not present or am incapacitated, BFP may share my information with family or friends that BFP has determined it is in my best interest and necessary for coordination of care.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature of Patient or Legal Representative Date

Burrows Family Practice, Inc.

Nurse Practitioner / Physician Assistant Consent Form:

Burrows Family Practice has on staff a PA/NP to assist in the delivery of medical care. A Physician Assistant (PA) / Nurse Practitioner (NP) is not a doctor. A PA/NP is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a PA/NP can diagnose, treat and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the the physician, rather the overseeing of activities of and accepting responsibility for the medical services provided.

I (Print Patient Name) _____ Date of Birth_____
have read the above information, and consent to the services of a PA/NP for my health care needs. I understand I can refuse the service of a PA/NP at anytime and request the service of the Physician.

_____

Signature of Patient or Legal Representative Date

Electronic Communication Consent Form:

Completion of this form allows BFP to communicate with you electronically regarding your protected health information. This portal is not intended for any urgent medical needs or appointment requests. A response will be given within 4 business days.

PATIENT'S ACKNOWLEDGMENT AND AGREEMENT: I have read the above information.

_____ I choose NOT to activate my portal account.

_____ Yes, I would like to activate my portal account. I understand BFP cannot guarantee complete security and confidentiality in communication electronically, and will not be liable for inadvertent disclosures of confidential information that occurs outside the scope of our security measures.

Patient Email Address_____

Patient Signature_____ **Date**_____

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Telehealth Consent Form

1. My health care provider wishes me to engage in a telehealth consultation and has explained to me how the video conferencing technology will be used to affect such a consultation and that it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I have met the following criteria for a telehealth consultation:
   a. I have an Apple device with Facetime for the consultation
   b. I have an Android device with WhatsApp Messenger installed on my smart phone for the consultation.
3. I understand there are potential risk to this technology, including interruptions, unauthorized access and technical difficulties. I further understand that my healthcare information may be shared with other individuals for scheduling, billing purposes and video operation, and that I will be informed of their presence. I have the right to request the following: 1) omit specific details of my medical history/physical examination 2) ask non-medical personnel to leave the telehealth exam room and or 3) terminate the consultation at any time.
4. I understand that billing will occur from my practitioner for this telehealth visit. Co-payments will be due and payable before the telehealth consultation. Payments may be made on the www.**BurrowsFamilyPractice.org** website.

_____ _____

Print Patient First and Last Name Date of Birth

_____ _____

Patients Signature Date

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