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 ☐ Jeffrey Mandl, NP

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship:_____

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

ACCOUNT INFORMATION

The **Primary Insurance Holder** (the person that pays for the insurance plan which is called the policy holder):
☐ Self ☐ Other (please complete)

Policy Holder: _____ 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.

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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.

_____ _____

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

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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 - Health History Questionnaire

Name:_____ **DOB:** _____ **Date:** _____

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

- ☐ Anemia
- ☐ Cancer or Tumor
- ☐ Glasses / Contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing Loss
- ☐ Allergies
- ☐ Dentures
- ☐ Dental Problems
- ☐ Angina
- ☐ Rheumatic Fever
- ☐ High Cholesterol
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Emphysema
- ☐ Asthma
- ☐ Heartburn
- ☐ Ulcer Disease
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Hemorrhoids
- ☐ Color Polyp
- ☐ Prostate problems
- ☐ Arthritis or Joint Pain
- ☐ Gout
- ☐ Broken Bones
- ☐ Seizure
- ☐ TIA
- ☐ Stroke
- ☐ Depression
- ☐ Anxiety / Panic Attacks
- ☐ Suicide Attempt
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Mental Illness
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Sexually Transmitted Diseases
- ☐ Abnormal Pap Smear
- ☐ Abnormal Mammogram
- ☐ Breast Lump
- ___ # of Pregnancies
- ___ Live Births
- ___ Miscarriages
- ___ Abortions

Have you even been exposed to or do you have a family member with …

- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ TB

Other **medical conditions not listed above**:

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

List **all surgeries** you have had:

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

List **all medication** allergies:

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

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

1. _____
2. _____
3. _____
4. _____

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

1. _____
2. _____
3. _____
4. _____

5. _____ 5. _____

6. _____ 6. _____

7. _____ 7. _____

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) _____

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**:

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

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

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Osteoporosis
- ☐ Skin Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ High Cholesterol

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

Father: _____ Mother: _____

Brother(s): _____ Son(s): _____

Sister(s): _____ Daughter(s): _____

REVIEW OF SYSTEMS:

Current health symptoms. Please complete all questions.

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