Premier
Family Medicine

2283 S Monaco Pkwy, Ste. 105
Denver, CO 80222
Ph: (720) 531-2370 Fax: (303) 632-6153

PATIENT DEMOGRAPHICS

FIRST NAME _____ MIDDLE _____ LAST _____

DATE OF BIRTH _____ SEX F _____ M ____

ADDRESS _____ CITY_____ STATE _____ ZIP _____

APT # _____

HOME PHONE _____ CELL _____ WORK _____

EMERGENCY CONTACT _____

PHONE _____ RELATION _____

LEGAL GUARDIAN (IF PATIENT IS A CHILD UNDER 18) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

*****PREFERRED PHARMACY:**_____

**HOW DID YOU HEAR ABOUT US? (PLEASE SPECIFY)

- ☐ ONLINE (Circle One): **Google** **Yelp** **Zocdoc**
- ☐ FRIEND
- ☐ FAMILY MEMBER _____
- ☐ OTHER (please specify) _____

PLEASE PROVIDE YOUR INSURANCE CARD, STATE ISSUED ID, AND ANY IMMUNIZATION RECORDS TO THE RECEPTIONIST.

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Note: This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Chief Complaint/History of Present Illness

What is the reason for your visit? (Be as specific as possible)

Review of Symptoms

Do you currently have any of the following problems? Please check Yes or No

Constitutional Symptoms			*Cardiovascular*			*Skin*		
Fever	Y ☐	N ☐	Chest Pain	Y ☐	N ☐	Rash/Sores	Y ☐	N ☐
Chills	Y ☐	N ☐	Swelling in Legs	Y ☐	N ☐	Mole Changes	Y ☐	N ☐
Fatigue	Y ☐	N ☐	Palpitations	Y ☐	N ☐	Skin Color Change	Y ☐	N ☐
Weight Loss	Y ☐	N ☐	High Blood Pressure	Y ☐	N ☐	Eczema	Y ☐	N ☐
Weight Gain	Y ☐	N ☐						
			Gastrointestinal			*Endocrine*		
Neurologic			Abdominal Pain	Y ☐	N ☐	Hair Loss	Y ☐	N ☐
Dizziness	Y ☐	N ☐	Nausea	Y ☐	N ☐	Heat Intolerance	Y ☐	N ☐
Seizures	Y ☐	N ☐	Vomiting	Y ☐	N ☐	Cold Intolerance	Y ☐	N ☐
Numbness	Y ☐	N ☐	Frequent Heartburn	Y ☐	N ☐	Excessive Thirst	Y ☐	N ☐
Tingling	Y ☐	N ☐	Constipation	Y ☐	N ☐	Thyroid Problem	Y ☐	N ☐
Headache	Y ☐	N ☐	Diarrhea	Y ☐	N ☐	Excessive Sweating	Y ☐	N ☐
			Blood in Stool	Y ☐	N ☐			
Eyes						*Hematologic/Lymphatic*		
Blurred Vision	Y ☐	N ☐	*Musculoskeletal*			Swollen Glands	Y ☐	N ☐
Double Vision	Y ☐	N ☐	Joint Pain	Y ☐	N ☐	Frequent Bruising	Y ☐	N ☐
Vision Loss	Y ☐	N ☐	Joint Stiffness	Y ☐	N ☐	Blood Clots	Y ☐	N ☐
Eye Pain	Y ☐	N ☐	Muscle Pain	Y ☐	N ☐			
			Restricted Motion	Y ☐	N ☐	*Allergic/Immunologic*		
Ear/Nose/Throat/Mouth			Back Pain	Y ☐	N ☐	Hay Fever	Y ☐	N ☐
Sore Throat	Y ☐	N ☐				Medications	Y ☐	N ☐
Sinus Problems	Y ☐	N ☐	*Psychiatric*					
Hearing Problems	Y ☐	N ☐	Depression	Y ☐	N ☐	*Genitourinary*		
Nosebleeds	Y ☐	N ☐	Anxiety	Y ☐	N ☐	Urine Leakage	Y ☐	N ☐
			Psychiatric Disorders	Y ☐	N ☐	Blood in Urine	Y ☐	N ☐
Respiratory			Hallucinations	Y ☐	N ☐	Burning w/ Urination	Y ☐	N ☐
Wheezing	Y ☐	N ☐	Thoughts of Suicide	Y ☐	N ☐			
Shortness of Breath	Y ☐	N ☐				Other (Please Specify)		
Cough	Y ☐	N ☐	*Breast*			1.		
Sleep Apnea	Y ☐	N ☐	Nipple Discharge	Y ☐	N ☐	2.		
Asthma	Y ☐	N ☐	Lumps	Y ☐	N ☐	3.		

Medications/Allergies

Are you on any medications? Yes ☐ No ☐ (If yes, list all)

Do you have any allergies? Yes ☐ No ☐ (If yes, list all)

Hospitalizations and Surgeries in Last 10 Years:

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Social History

Do you smoke?	Yes ☐	No ☐	How often? _____	For how long? _____
Do you smoke marijuana?	Yes ☐	No ☐	How often? _____	For how long? _____
Do you drink alcohol?	Yes ☐	No ☐	How often? _____	For how long? _____
Do you use any street drugs?	Yes ☐	No ☐	How often? _____	For how long? _____

Family History

Has any relative ever had (Please specify if maternal or paternal):

	Who		Who		Who
☐ Stroke		☐ Heart Trouble		☐ Mental Illness	
☐ Cancer		☐ High Blood Pressure		☐ Dementia/Alzheimer's	
☐ Diabetes		☐ Kidney Trouble		☐ Tuberculosis	
☐ Epilepsy		☐ Sickle Cell Disease		☐ Bleeding Problems	

Past Medical History

Have you ever had any of the following?

☐ Anemia	☐ Anxiety	☐ Asthma	☐ Bladder Infection
☐ Blood Clot in Legs/Lung	☐ Blood Transfusion	☐ Cancer	☐ Chlamydia
☐ Depression	☐ Diabetes	☐ Drug or Alcohol Problem	☐ Gall Bladder Disease
☐ Genital Herpes	☐ Gonorrhea	☐ Heart Disease	☐ High Blood Pressure
☐ Kidney Disease	☐ Liver Disease	☐ Migraines	☐ Mitral Valve Prolapse
☐ Osteopenia/Arthritis	☐ Pelvic Infection	☐ Pneumonia	☐ Rheumatic Fever
☐ Seizures	☐ Sickle Cell Trait	☐ Syphilis	☐ Thyroid Problem

Last Colonoscopy _____ Last Bone Density _____ Last Cholesterol Check _____

Past Obstetrical History

Please list all pregnancies in order (including miscarriages, premature births, abortions, etc.):

)ate	Sex	Weight	Type of Delivery	Weeks Pregnant	Anesthetic	Complications

Past Gynecological History

Date of Beginning of Last Menstrual Period _____ Method of Birth Control _____

Age of First Period _____ Are Your Periods Regular? Yes ☐ No ☐ Cycle Length _____

Are you Sexually Active? Yes ☐ No ☐ Date of Last Pap Smear _____ Past Abnormal Pap? Yes ☐ No ☐

Have you had treatment for an abnormal pap smear? (please list what and when) _____

Date of Last Mammogram _____ Was it Normal? Yes ☐ No ☐

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PREMIER FAMILY MEDICINE
PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize *Premier Family Medicine* to use and disclose my protected health Information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
* Obtaining payment from third party payers (e.g. my Insurance company);
    - The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of *Notice of Privacy Practices*; which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that *Premier Family Medicine* reserves the right to change the terms of this notice from time to time and that I may contact *Premier Family Medicine* at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that I am not required to agree to these requested restrictions - However, if I do agree, I am then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name_____ Date of Birth

_____

Signature _____ Date Signed _____

Relationship to Patient (circle one):

Self Parent Legal Guardian Other (please specify) _____

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PHONE INFORMATION RELEASE FORM

Patient Name: _____ Date of Birth: _____

Please call: [ ] My Home [ ] My Work [ ] My Cell

If unable to reach me:

[ ] You may leave a detailed messages

[ ] Please leave a message asking to return your call

[ ] Do not leave a message

[ ] Other (specify) _____

Patient Signature: _____ Date: _____

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MEDICAL INFORMATION RELEASE FORM

Patient Name: _____ DOB: _____

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

Phone: (_____) _____ Email (Optional): _____

[ ] I, _____, authorize the release of my medical information and records TO the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

[ ] I, _____, authorize the release of my medical information and records FROM the following entities:

(1) Business Name: _____

Address: _____ City: _____, State: _____ Zip Code: _____

Phone: _____ Fax: _____

(2) Business Name: _____

Address: _____ City: _____, State: _____ Zip Code: _____

Phone: _____ Fax: _____

Types of medical information and records to be released:

- Entire medical records including office visit notes, discharge summery, lab results, and radiology reports. This includes all addiction and psychiatry-related notes.
- Lab Results
- Radiology Reports
- Other (please specify): _____

[ ] I do not authorize the release of my medical information and records to anyone without my written permission. I understand that my refusal to sign this form will not adversely affect my ability to receive health care services.

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Patient Signature: _____ Date: _____

Missed Appointment Agreement

To serve you better and keep the cost of medical care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when patients fail to keep scheduled appointments or cancel at the last minute. Appointments are reserved exclusively for you. A scheduled appointment is a commitment between you and our practice as a promise to appear.

- We require at least 24 hours (1 business day) notice for any cancelled or rescheduled appointment.
- We reserve the right to charge and collect $25 per half hour for any missed appointment.
- A missed appointment is considered a scheduled appointment in which you no show or a cancelled appointment with less than 24 hours (1 business days) advanced notice.
- If you have missed multiple appointments, we will require $50 to reserve your next appointment. This fee will be applied towards your completed appointment or treatment.

We sincerely appreciate your understanding and cooperation with our clinic policy.

Patient or Responsible Party Name: _____

Signature of Patient or Responsible Party: _____

Date: _____

Relationship (please circle one): Self Parent Legal Guardian

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PATIENT FINANCIAL RESPONSIBILITY FORM

1. ***INDIVIDUAL'S FINANCIAL RESPONSIBILITY***
   - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
   - Co-payments are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured, I agree to pay in full for the medical services rendered to me at time of service.

2. ***INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS***
   I hereby authorize and direct payment of my medical benefits to *Premier Family Medicine* on my behalf for any services furnished to me by the providers.

3. ***AUTHORIZATION TO RELEASE RECORDS***
   I hereby authorize *Premier Family Medicine* to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. ***MEDICARE REQUEST FOR PAYMENT***
   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in *Premier Family Medicine*. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.

_____ _____
Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

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