PATIENT INFORMATION FORM

IMPORTANT: FILL OUT COMPLETELY

PATIENT NAME (LAST – FIRST – MIDDLE)		SEX M F	BIRTH DATE	MARITAL STATUS S M D W
ADDRESS / STREET	CITY	STATE	ZIP CODE	HOME PHONE ( )
NAME OF EMPLOYER	OCCUPATION	WORK PHONE ( )	PATIENT SSN	CELL PHONE ( )
E-MAIL		PREFERRED PHARMACY LOCATION		

PARENT/GUARDIAN/SPOUSE'S NAME (LAST-FIRST-MIDDLE)	BIRTH DATE	SOCIAL SECURITY NUMBER	PHONE #
NEAREST RELATIVE NOT LIVING WITH YOU		PHONE NUMBER	
NEAREST FRIEND NOT LIVING WITH YOU		PHONE NUMBER	

IN CASE OF AN EMERGENCY CONTACT – NAME	RELATIONSHIP	PHONE NUMBER

LANUAGE PREFERENCE- (PLEASE CIRCLE ONE)			ETHNICITY- (PLEASE CIRCLE ONE)	DO YOU WEAR SEATBELTS? Y N
ENGLISH	ITALIAN	RUSSIAN	HISPANIC OR LATINO	DO YOU USE TOBACCO? Y N CURRENT PACKS/DAY_____ YEAR QUIT_____
CHINESE	JAPANESE	SPANISH	NON HISPANIC OR LATINO	DO YOU USE RECREATIONAL DRUGS? Y N TYPE_____
FRENCH	KOREAN	REFUSE	REFUSE	DO YOU USE ALCOHOL? Y N HOW OFTEN? _____
GERMAN	PORTUGUESE			

RACE (PLEASE CIRCLE ONE)
AMERICAN INDIAN & ALASKAN NATIVE
ASIAN
BLACK OR AFRICAN AMERICAN
BLACK HISPANIC OR LATINO
NATIVE HAWAIIAN & OTHER PACIFIC ISLANDER
WHITE
WHITE HISPANIC OR LATINO
REFUSE

FAMILY MEMBER INFORMATION LIVING IN THE SAME HOUSEHOLD

NAME	SEX	BIRTH DATE	NAME	SEX	BIRTH DATE

I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE

SIGNATURE _____ DATE _____

INSURANCE INFORMATION

POLICY HOLDER NAME _____ ID # _____

Welcome to Our Practice

As a new patient, please fill out the information found below to the best of your ability.

Patient #_____ Physician_____ Date _____

Patient Name_____ Chief Complaint _____

History of Present Illness:

Location _____ (Where is the pain/problem?)

Quality _____ (Example: normal versus abnormal color, activity, etc.)

Severity _____ (How severe is the pain/problem on a scale of 1-5 (5 being the most severe)?)

Duration _____ (How long have you had this pain/problem or when did it start?)

Timing _____ (Does the pain/problem occur at a specific time?)

Context _____ (Where were you at the onset of this pain/problem?)

Associated Signs/ Symptoms _____ (What other associated problems have you been having?)

Modifying Factors _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

Patient Medical History:

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes	Blood or Plasma Transfusions	☐ No	☐ Yes	Mitral Valve	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Anemia	☐ No	☐ Yes	Back Trouble	☐ No	☐ Yes	Prolapse	☐ No	☐ Yes
Chickenpox	☐ No	☐ Yes	Bladder Infections	☐ No	☐ Yes	High or Low Blood Pressure	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Whooping Cough	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Scarlet Fever	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes
Diptheria	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Hives or Eczema	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Smallpox	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Infectious Mono	☐ No	☐ Yes	Bleeding Tendency	☐ No	☐ Yes
Rhematic Fever	☐ No	☐ Yes	Polio	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes	Any Other Disease	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Date of last chest X-ray: _____			(please list) _____		
Arthritis	☐ No	☐ Yes	Hernia	☐ No	☐ Yes				_____		
									_____		

Previous Hospitalization/Surgeries/Serious Illness

	When	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (include nonprescription):

_____

Patient Social History:

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously, but quit: _____ ☐ Current packs/day _____

Use of drugs: ☐ Never ☐ Type/frequency: _____

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

Good general health lately	☐ No	☐ Yes
Recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes

EYES

Eye disease or injury	☐ No	☐ Yes
Wear glasses/contact lenses	☐ No	☐ Yes
Blurred or double vision	☐ No	☐ Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	☐ No	☐ Yes
Earaches or drainage	☐ No	☐ Yes
Chronic sinus problems or rhinitis	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Bad breath or bad taste	☐ No	☐ Yes
Sore throat or voice change	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes

CARDIOVASCULAR

Heart trouble	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes
Palpitation	☐ No	☐ Yes
Shortness of breath walking or lying flat	☐ No	☐ Yes
Swelling of feet, ankles or hands	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent coughs	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetitie	☐ No	☐ Yes
Change in bowel movements	☐ No	☐ Yes
Nausea or vomiting	☐ No	☐ Yes
Frequent diarrhea	☐ No	☐ Yes
Painful bowel movements or constipation	☐ No	☐ Yes
Rectal bleeding or blood in stool	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes

GENITOURINARY

Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Change in force of strain when urinating	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Kidney stones	☐ No	☐ Yes
Sexual difficulty	☐ No	☐ Yes
Male - testicle pain	☐ No	☐ Yes
Female - pain with periods	☐ No	☐ Yes
Female - irregular periods	☐ No	☐ Yes
Female - vaginal discharge	☐ No	☐ Yes

Female - # of pregnancies: _____

Female - # of miscarriages: _____

Female - date of last pap smear: _____

MUSCULOSKELETAL

Joint pain	☐ No	☐ Yes
Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles or joints	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Cold extremities	☐ No	☐ Yes
Difficulty in walking	☐ No	☐ Yes

INTEGUMENTARY (Skin, Breast)

Rash or itching	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Change in hair or nails	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Breast discharge	☐ No	☐ Yes

NEUROLOGICAL

Frequent or recurring headaches	☐ No	☐ Yes
Light headed or dizzy	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Numbness or tingling sensations	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Head injury	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Nervousness	☐ No	☐ Yes
Drepression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

ENDOCRINE

Glandular or hormone problem	☐ No	☐ Yes
Excessive thirst or urination	☐ No	☐ Yes
Heat or cold intolerance	☐ No	☐ Yes
Skin becoming dryer	☐ No	☐ Yes
Change in hat or glove size	☐ No	☐ Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	☐ No	☐ Yes
Bleeding or brusing tendency	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes
Past transfusion	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to

Penicillin or other antibiotics	☐ No	☐ Yes
Morphine, Demerol, or other narcotics	☐ No	☐ Yes
Novocain or other anesthetics	☐ No	☐ Yes
Asprin or other pain remedies	☐ No	☐ Yes
Tetanus antitoxin or other serums	☐ No	☐ Yes
Iodine, methiolate or other antiseptics	☐ No	☐ Yes

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the qustions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X _____ _____

Signature of patient (or parent if minor) Date

Doctor's Review: _____

Acknowledgement of Receipt of Notice

Dynamic Healthcare Team

2855 Dublin Boulevard, Colorado Springs, CO 80918

Julie, Office Manager 719-265-6464

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

Signed:_____ Date:_____

Print Name:_____ Phone:_____

If not signed by the patient, please indicate the relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Beneficiary or personal representative of deceased patient

Name of Patient:_____

_____

For Office Use Only:

Signed form received by:_____

Acknowledgment refused:

Efforts to obtain:_____

_____

Reasons for refusal:_____

_____

Confidential Channel of Communication Request

Dynamic Healthcare Team
2855 Dublin Boulevard
Colorado Springs, CO 80918
(P) 719-265-6464 (F) 719-265-6750

I, _____ (print),

DO DO NOT (circle one)

authorize the following individual _____(print) as a confidential channel for any communications of information related to my personal health, treatment, or payment for treatment. This request supersedes any prior request for confidential channel communications I have made.

Excluding:_____

_____

_____

_____

Patient Signature: _____ Date: _____

Printed Patient Name:_____

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

Dynamic Healthcare Team
FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our commitment is to provide quality treatment for you. Please understand that payment of your bill is considered a part of your partnership in treatment. This is a statement of our Financial Policy. We require you read and sign this prior to treatment.
All patients must complete our Information and Insurance forms before being seen at this office.
Full payment for services and / or co-insurance payment are due at time of service. We accept cash, checks, VISA/MASTERCARD or DISCOVER.

Regarding Insurance
We may accept assignment of insurance benefits if your insurance is accepted at this office. Any remaining balance is your responsibility. In order for us to bill your insurance company you must give us current and correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance policy.
Regarding Insurance Plans in which we are a participating provider: All co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan for which we are not participating providers, refer to above paragraph.

Collections and Billing
1. Our billing cycle occurs at the end of every month.
2. A $5.00 rebilling fee will be added to any account, if it is necessary to submit a bill to the patient; this is simply to cover our costs (postage, employee time, etc.) incurred in billing.
3. Unfortunately, at times in the past, some patients have not been responsible about paying their Doctor bills. If an account has been billed for 3 months without payment or sufficient cooperation on the part of the patient, the account is turned over to collections.
4. Any overdue account that is turned over to collections will be charged an additional 33.3% to cover collections costs.
5. We will not intentionally turn any account over to collections if the patient is cooperating and making an effort to keep their account current.
6. If you think there has been an error on your account you must notify us within 30 days and we will make every effort to correct the situation.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients
The parents or guardians of any minor seen in this office are responsible for full payment. For unaccompanied minors, non-emergency treatment cannot be delivered unless consent for treatment has been given and charges have been pre-authorized to a Visa/MasterCard or Discover, or payment is cash or check at time of service has been verified.

Missed Appointments
Please help us to serve you by keeping scheduled appointments. If you will be unable to keep your scheduled appointment-you must cancel it on the preceding day. If an appointment is missed and not cancelled by the preceding day, our policy is to charge $10.00 for a regular appointment and $30.00 for a 30-minute visit.

Medical Records Release and Statement of Understanding
I hereby authorize the release of any medical information required by my health plan. I hereby agree to abide by the above "Financial Policy".

_____ _____
SIGNATURE of PATIENT or PARENT/GUARDIAN *NAME OF PATIENT (PRINT)*

DATE: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dynamic Healthcare Team is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Dynamic Healthcare Team please contact:

Julie Tunney Office Manager, 2855 Dublin Blvd. Colorado Springs, CO 80918. 719-265-6464

Effective Date of This Notice: April 25, 2019

I. How Dynamic Healthcare Team (DHT) may Use or Disclose Your Health Information

DHT collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of DHT, but the information in the medical record belongs to you. DHT protects the privacy of your health information. The law permits DHT to use or disclose your health information for the following purposes:

1. Treatment. DHT may use or disclose your health information for the purpose of providing, or allowing others to provide treatment to you or any other individual. An example would be if your physician discloses your health information to another doctor for the purposes of a consultation. Also, we may contact you with appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

2. Payment. DHT may use and/or disclose your health information for the purpose of allowing this office, as well as other entities, to secure payment for the health care services provided to you. For example, DHT may inform your health insurance company of your diagnosis and treatment in order to assist the insurer in processing our claim for payment for health care services provided to you.

3. Regular Health Care Operations. DHT may use and or disclose your information for the purposes of its day-to-day operations and functions. DHT may also disclose your information to another covered entity to allow it to perform its day-to-day functions, but only to the extent that we both have a relationship with you or we have a Business Agreement to accomplish a specific task. For example, DHT staff will enter your information into our computer system for scheduling appointments.

4. Information provided to you.

5. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by law. As required by law, we may use and disclose your health information.

7. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

10. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

11. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.

12. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

13. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or DHT privacy board.

14. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military, national security, prisoner and government benefits purposes.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.