Name: _____

FAMILY CARE
SOUTHWEST, P.C.

Fax (303) 933-8147
Mail 6169 S Balsam Way, #250, Littleton CO 80123

New Patient History Form

Name: _____ DOB: _____ Allergies:

_____

Mailing Address: _____City State: _____

Zip Code: _____Home #: _____ Cell#: _____

Work #: _____

E-Mail Address: _____

Emergency Contact: _____ Phone#:_____ Relationship: _____

Preferred Pharmacy: (name and location):

_____

Prescription Medication, Vitamins, Supplements: □ NONE

1) _____ Dosage: _____# of times a day: _____
2) _____ Dosage: _____# of times a day: _____
3) _____ Dosage: _____# of times a day: _____
4) _____ Dosage: _____# of times a day: _____
5) _____ Dosage: _____# of times a day: _____

Past Medical History

□ Anxiety	□ Blood Clots	□ Gallbladder Disease	□ Osteoporosis
□Arthritis	□ Cancer	□ GERD (reflex)	□ Peptic Ulcer Disease
□ Allergies	□ Chest Pain	□ Heart Attack	□ Prostate Enlargement
□ Anemia	□ COPD	□ Kidney Disease	□ High Blood Pressure
□ Asthma	□ Chron's Disease	□ High Cholesterol	□ Atrial Fibrillation
□ Angina	□ Depression	□ Heart Disease	□ Thyroid Disease
□ Liver Disease	□ Migraines - Headaches	□ Irritable Bowel Disease	□ Coronary Artery Disease
□ Hepatitis B or C	□ Diabetes	□ Seizure Disorder	□ Bladder reflux
□ Osteoarthritis	□ Colitis / Diverticulitis		

Name: _____

Other: _____

_____

Past Surgical History- Please list the year procedure was done

□ Angioplasty _____ □ Colectomy_____ □ Bone Surgery _____

□ Angioplasty with Stent _____ □ Colostomy_____ □ Pacemaker_____

□ Appendectomy _____ □ Gastric Bypass_____ □ Small Bowel Resection _____

□ Hernia Repair _____ □ Thyroidectomy_____ □ Tonsillectomy_____

□ Joint Replacement R/L Hip _____

□ Joint Replacement R/L Knee _____

□ Back Surgery _____ □ Carpal Tunnel R/L _____

□ LASIK _____ □ Cataract Extraction _____

□ Gallbladder Removal _____ □ Liver Biopsy _____

□ Heart Bypass _____ □ Tubal litigation _____

□ Vasectomy_____ □ TURP (prostate) _____

Other: _____

Females Only:

□ Colonoscopy Date __/__/__ □ Last Period __/__/__ □ Date of last Pap __/__/__
Normal □ Yes □ No □ Postmenopausal Y or N Year _____ □ History of abnormal pap? Y or N
Year _____

□ Hormone Replacement Therapy □ Treatment for abnormal pap
Y or N Year _____

□ Freezing, LEEP or Observation

□ Bone Density Date __/__/__ □ Post-menopausal bleeding Y or N □ Gardasil Vaccine Y or N
Normal □ Yes □ No □ Pregnancies Total: _____ □ History of STD's Y or N

Males Only

- Colonoscopy Date ___/___/_____ Prostate Exam Date ___/___/_____
  Normal- Yes or No Normal Yes or No
- Bone Density Test Date ___/___/_____ PSA Date ___/___/_____
  Normal Yes or No Normal Yes or No
- Cholesterol Date ___/___/_____ History Of STD's Yes Or No

  Normal Yes or No Type: _____

Name: _____

☐ Testicular Exam Date ___/___/_____
Normal Yes or No

Family History-Please list RELATION and AGE of onset and/or death

ADD/ADHD_____ Alcoholism_____ Allergies _____

Alzheimer's _____ Asthma _____ Blood Disease _____

CAD _____ CAD-Premature _____ Cancer _____

Depression _____ Developmental Delay _____ Diabetes _____

Eczema _____ Hearing Deficiency _____ High Cholesterol _____

High Blood Pressure _____ Irritable Bowel Disease _____ Learning Disability _____

Mental Illness _____ Migraines _____ Obesity _____

Osteoarthritis _____ PVD _____ Renal Disease _____

Seizure Disorder _____ Stroke _____ Other _____

Social History

Primary Language _____ Language Spoken at Home_____
Birthplace _____

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Name: _____

We are required to collect this information.

We need to show we are collecting patient information with our certified Electronic Health Record (EHR) technology in ways that can be measured significantly in quality and in quantity. The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of a certified EHR technology for electronic exchange of health information to improve quality of healthcare.
3. The use of certified EHR technology to submit clinical quality and other measures.

Hand Dominance Right or Left

Highest Level of Education_____ Type of Degree Earned _____
Employer_____Occupation_____
Any Work Restrictions _____ Occupational Hazards _____
Full Time _____ Part Time _____ Retired_____ When? _____
Military Experience Yes or No
Marital Status_____ People living in household _____
Sexual Orientation _____Contraception (type) _____
Sexual Partners in Lifetime □ < 5 □ > 5 □ > 10

Tobacco Use	□ Yes	□ No	□ Former	Units/Day _____ Age Started _____
Alcohol Use	□ Yes	□ No	□ Former	Frequency _____ Last Drink _____
Illicit Drug Use	□ Yes	□ No	□ Former	Frequency _____ Type _____
Caffeine Use	□ Yes	□ No	Type _____	Caffeine / Day _____
Exercise	□ Yes	□ No	Type _____	Hours / Week _____
Animals in Home	□ Yes	□ No		

Recent Travel □ Yes □ No Out of State Out of Country
Where_____

Signature: _____ Date: _____

Name: _____

HIPAA Consent

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With My Consent, Family Care Southwest P.C. (FCSW), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Family Care Southwest's Notice of Privacy Practices for a more complete description of such uses of disclosures.

I have the right to review the Notice of Privacy Practices before signing this consent. FCSW reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Family Care Southwest Privacy Officer at 6169 S. Balsam Way, Suite 250, Littleton, CO 80123.*

With my consent, FCSW may call my home or other designated location, and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out my treatment, payment, and healthcare operations; such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results.

With my consent, Family Care Southwest may mail to my home or other designated location any items that assist the practice in carrying out TPO; such as appointment reminder cards and patient statements, as long as they are marked *Personal and Confidential.* I have the right to request that Family Care Southwest, P.C. restrict how it uses or discloses my protected health information (PHI) to carry out my TPO.

By signing this form, I am consenting to Family Care Southwest, P.C.'s use and disclosure of my protected health information to carry out my treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosure based on my prior consent. FCSW requires written consent before providing treatment to patients.

_____

Date

_____ _____

Signature of Patient Signature of Legal Guardian

_____ _____

Printed Patient Name Printed Legal Guardian Name

Name: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO FAMILY CARE SOUTHWEST P.C.

303-933-4555 Office 303-933-8147 Fax

Records Request From:

Doctor: _____

Address: _____

_____

Fax and phone # _____

SEND TO: Family Care Southwest PC
6169 S Balsam Way #250
Littleton, CO 80123

Patient's Name: _____ Phone #_____

Date of Birth: _____

I authorize the health care provider to release the information specified below to Family Care Southwest P.C. I specifically authorize the release of information regarding the following condition(s):

Initials **Initials**

_____ Drug Abuse If Any _____ Substance Abuse If Any

_____ Psychological/Psychiatric _____ AIDS/HIV If An

_____ Other Conditions if Any _____

Initials **Initials**

1. All Medical records at this facility _____ 2. Only records generated by this facility (not Including records from other sources) _____

3. Only some portions of records Maintained at facility (specify below).

_____

_____

I understand this authorization will expire, with my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I accept full financial responsibility for copying fee. **Our policy is to release only the Designated Record Set (DRS) originating within our office and any requested tests ordered by our providers**

_____ _____

Patient Name (Print) Person Authorized to Sign for Patient:

_____ _____

Patient's Signature Signature

_____ _____

Date Relationship to Patient

Name: _____

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTY

By signing this authorization, I _____ authorize Family Care Southwest P.C. to release any and/or all protected health information (PHI) about me to or for the party or parties listed below. This may include i.e. test results, treatment, billing matters, social information, etc. If phone numbers are listed below you have my permission to leave a phone message directly with the person(s) listed below. I understand by leaving this section blank, it indicates that I do not grant permission for Family Care southwest to speak with a family and/or trusted friend.

The authorization permits **Family Care Southwest** to use or disclose to:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

By initialing below, I authorize **Family Care Southwest, P.C.** to release any information specified below to the person(s) listed above. If the below categories are not initialed, information to this nature will not be disclosed.

I specifically authorize the release of information regarding the following condition(s):

Initials		**Initials**	
_____	Drug Abuse (If Any)	_____	Substance Abuse (If Any)
_____	Psychological/Psychiatric (If Any)	_____	AIDS/HIV (If Any)

Please indicate in the space below the nature of the information you wish to release. If you wish to release "any and/or all protected health information," please indicate this below. If you wish to release only specific portions of your medical record, please designate these below:

_____

_____

This authorization will expire on ___ / ___ / 20____.

When my information is used or disclosed pursuant through this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Family Care Southwest P.C. has acted in reliance upon this authorization. My written revocation must be submitted to ***Family Care Southwest P.C., 6169 South Balsam Way suite 250, Littleton CO 80123***. **Unless there is an expiration date given, this authorization will expire in 5 years. **

_____ _____/ 2016

Signature of Patient and or Legal Representative Date

_____ _____

Printed Name If Legal Representative, Please Indicate What Type (ie: Medical Power of Attorney, Power of Attorney, etc.)

"By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due and collections, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receive messages from my healthcare provider, when necessary."