PEAK HEALTH
FAMILY MEDICINE

Patient Medical History Form

NAME: _____Date_____ AGE: _____ DATE OF BIRTH: _____
RACE: _____ETHNICITY: _____ PREFERRED LANGUAGE: _____M/F_____
PRONOUNS:_____SEXUAL ORIENTATION:_____
REASON FOR TODAY'S VISIT:

_____

ALLERGIES and/or REACTIONS TO MEDICINES:

_____

CURRENT MEDICATIONS: Prescription, non-prescription medicines, and vitamins.
Medication Dose (e.g., mg/pill) how many times/days when started? Please check the Aspirin.

_____

_____

ASPIRIN USAGE: Daily_____ Dosage: 81mg or 325mg? _____ Occasional _____ Never____

PERSONAL MEDICAL HISTORY: Do you or have you had any of these problems?

Yes	Date	MEDICAL PROBLEM	Yes	Date	MEDICAL PROBLEM
		High Blood Pressure			Kidney Stones
		High Cholesterol			Urinary Tract Infection (recurrent)
		Diabetes Type 1			Fracture which bones? _____
		Diabetes Type 2			Arthritis Rheumatoid? Yes/No
		Irregular Heartbeat			Gout
		Heart Attack			Breast Disease (non-cancerous)
		Heart Murmur			Thyroid Disease type? _____
		Congestive Heart Failure			STDs type? _____
		Stroke			HIV
		Asthma			Blood Clot/Pulmonary Embolus
		Emphysema/COPD			Blood Transfusion
		Pneumonia			Anemia
		Sleep Apnea (date of last sleep study_____) CPAP / BiPAP / O2 (circle)			Bleeding Disorder type? _____
		Stomach Ulcer			Allergies Seasonal/Year-Round
		Gall Stones			Skin Disease type? _____
		Liver Disease/Hepatitis type? ___			Cancer, Type _____
		Hemorrhoids			Dementia
		Ulcerative Colitis/Crohn's			Depression/Anxiety (circle applicable)
		GERD/Heartburn			Insomnia
		Chronic Pain location_____			Other_____

SPECIALISTS: Please list any specialists and their office information

_____

_____

_____

PEAK HEALTH
FAMILY MEDICINE

NAME: _____**DATE OF BIRTH:** _____

FAMILY MEDICAL HISTORY (List **Medical Conditions** ex: diabetes, high blood pressure, etc.):
Father: _____ Mother: _____

Paternal Grandfather: _____ Maternal Grandfather: _____

Paternal Grandmother: _____ Maternal Grandmother: _____

Brother: _____ Sister: _____

LIST ANY SURGERIES/HOSPITALIZATIONS: (reason and date)

_____

_____

_____

_____

Do you have advanced directives ("living will")? Yes / No (circle)

WOMEN'S GYNECOLOGICAL HISTORY:
Contraceptive Method: _____ Age of first period: _____
# of Pregnancies _____ # of Deliveries _____ # of Abortions _____ # of Miscarriages_____
Menopausal: No / Yes. If yes, what age? _____
Last PAP smear _____ History of Abnormal PAP smear? Yes / No
Last mammogram _____ History of Abnormal mammogram? Yes / No

HEALTH MAINTENANCE: When were your most recent screening tests?
PSA (Prostate cancer screen) (date) _____ Results? _____
Colonoscopy (date) _____ Results? _____
CIMT (Carotid Ultrasound) (date) _____ Results? _____
AAA (Abdominal Aorta Aneurysm ultra sound) (date) _____ Results? _____

IMMUNIZATIONS: Please indicate the **date** of your most recent:
Tetanus _____ Influenza _____ COVID-19 _____ Shingrix _____
Pneumovax23 (Pneumonia) _____ Prevnar13 (Pneumonia) _____ HPV _____

SOCIAL HISTORY: Tobacco Use (please circle one): Never / Cigarettes / E-Cigarettes Quit Date ____
Current Smoker: packs or cartridges/day _____ # of years: ____ Interested in quitting? Yes / No
Other Tobacco: *Pipe* *Cigar* *Chew* How often? _____
Alcohol Use: Do you drink alcohol? No / Yes
If Yes, How often (per week, month, etc.)? _____ How many drinks? _____
Is alcohol use a concern for you or others? No / Yes
Illicit Drug use? No /Not Currently/ Yes Name(s) of Drugs_____

SOCIOECONOMICS:
Occupation: _____ Employer: _____
Marital Status: S M D W Other: _____Spouse/Partner's name: _____
Children(s) Name(s):_____

EXERCISE: Do you exercise regularly? No / Yes
How long? (minutes) _____ How often? _____

Patient Name_____ Date of Birth_____ Todays Date_____

Consent for Medical Care

I hereby consent to medical care for myself or as the guardian of the above-named patient at Peak Health Family Medicine. I authorize my medical provider to provide the treatment deemed necessary for the benefit of the patient including but not limited to diagnostic testing, medications, and/or other therapeutic modalities. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I have read this consent and voluntarily certify that I understand and agree to its content.

Should you decide to establish care at another medical practice in the future, this will inherently terminate your relationship with Peak Health Family Medicine.

Authorization to Release Medical Information and Assign Insurance Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Peak Health Family Medicine, and any assisting medical providers for services rendered. Peak Health Family Medicine and its medical providers are authorized to release any medical information required in the processing of applications for financial coverage. I permit a copy of this authorization to be used in place of the original. I certify that the information given by me in applying for payment is correct. I authorize benefits be made in my behalf.

I guarantee payment of all charges on this patient/guarantor account and assign to the medical providers any and all benefits relating to this patient/guarantor account whether insured or self-funded. I further assign the proceeds of all claims, resulting from or relating to the financial liability of this account made by a third party: any person, employer or insurance company on behalf of this account, unless the account is paid in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance or other form of health benefit.

<u>It is my responsibility, and not Peak Health Family Medicine, to be knowledgeable of my medical insurance benefits, deductibles, copays and coinsurance.</u>

Personal Medical Records requested for by patients for personal use will be charged a fee.
Medical Records requested by another healthcare facility or provider are released free of charge once release consent is signed.

No Show Fee/Showing up Late Fees

Please give us 24 hours advanced notice if you cannot make it to your scheduled appointment. If you do not inform us of your inability to come to your scheduled appointment, we will charge a $50.00 no-show fee for a 20-minute scheduled appointment and a $100.00 no-show fee for a 40-minute scheduled appointment. In addition, you understand that if you show up late to your appointment, you may have to reschedule to the next available appointment because we value your time as well as the rest of our patients' time. If you show up late and cannot be seen, the above no show fees will apply.

We will continue to see “sick” patients during our sick hours and healthy patients during our “well” hours to minimize COVID risk. If your appointment needs to be rescheduled because you did not follow our COVID appointment guidelines (coming to your appointment when you are feeling ill during “well” hours), then you will be charged the above fees. Understand that if you call to cancel within 24 hours of your appointment because you are sick, you will NOT be charged. We do not want you to expose our healthy patients if you feel unwell.

Prescription Medications

I will give Peak Health Family Medicine a minimum of 48 business hours to refill Rx medication. I understand I should call my pharmacy for all refill request. I recognize it is my responsibility to call my pharmacy to discontinue auto re-fill and it is not the responsibility of Peak Health Family Medicine.

Phone Calls

We encourage patients to call with questions, but please understand we do not treat medical conditions over the phone since this is medically inappropriate and can result in misdiagnosis and/or inadequate care. Therefore, we prefer you schedule an appointment with a medical provider for proper care and treatment. For after-hours medical emergencies, we do have an on call medical provider who can determine whether or not you need to go to Emergency Department or wait to be seen in clinic.

Personal Liability

I understand that I am personally responsible for the charges resulting from care and treatment. Any payment received by Peak Health Family Medicine as a result of the above Authorization for Release of Medical Information and Assignment of Insurance Benefits will be credited toward my patient/guarantor account and I will be personally liable for any and all remaining balances on the account.

I further understand that if the third-party payor denies benefits or fails to make payment within 30 days of submission, I will be personally responsible for the entire balance on the account.

Privacy Notice

I have been provided the opportunity to receive a copy of the “Notice of Privacy Practices” that explains when, where, and why my confidential health information may be used or shared. I agree that a photocopy or digital image of this agreement shall be as valid as the original.

Print Name: _____ **Date of Birth: _____**
Signature: _____ **Date: _____**
Email Address: _____
Preferred Pharmacy: _____
Pharmacy Address: _____
Pharmacy Phone: _____

PEAK HEALTH
FAMILY MEDICINE

Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ DOB _____

Minor's Cell_____ (age 12-17)

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____ Phone:_____

[ ] Child(ren)_____Phone:_____

[ ] Parent _____Phone:_____

[ ] Parent _____Phone:_____

[ ] Other_____Phone:_____

[ ] Do NOT release information to anyone outside of healthcare.

I UNDERSTAND THAT THIS RELEASE WILL REMAIN IN EFFECT UNTIL OTHERWISE STATED BY ME IN WRITING.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] Please leave a detailed message on my voicemail.
[ ] Do NOT leave a voicemail. Please leave a message asking me to return your call.
[ ] _____
It is best to reach me: (day)_____ between (time)_____

Is it okay to email or send a text message as a reminder for any future appointments?
Yes: ____ Email: _____
No: ____

Signature: _____ Date: _____

Patient Name (First, Middle, Last):	DOB:
Address:	Phone:

This Authorization applies to the following Information:

[ ] **All Information**; I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

[ ] **Only** the following records or types of Information:

[ ] Office Visits [ ] Labs [ ] ETOH/substance abuse record

[ ] HIV/STD records [ ] Radiology [ ] Other (Please specify)

[ ] Mental Health record [ ] EKG, Spirometry _____

Treatment Dates: from (month/date/year): ____/____/_____ to _____/____/_____

Previous Medical Provider and Address:	Phone: Fax:
Disclose Information to:	
Peak Health Family Medicine **5920 S. Estes St. Suite 250** **Littleton, CO 80123**	Phone: 303-973-3529 Fax: 303-973-3549

Purpose of the release:

[ ] Change of Primary Care Provider [ ] **Other** *(Please specify):*_____

This authorization ends: [ ] on (date) _____ If no date is specified, this authorization will end after 180 days from date of signature.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Peak Health Family Medicine.

For patient medical records that exceed over 30 pages please send records by mail. We appreciate your help. Thank you in advance.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Peak Health Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

_____ _____ _____

Signature of Patient/Legal Guardian **Printed Name** of Patient/Legal Guardian Date