PEAK HEALTH
FAMILY MEDICINE

Patient Medical History Form

NAME: _____Date_____ **AGE:** _____ **DATE OF BIRTH:** _____
RACE: _____ **ETHNICITY:** _____ **PREFERRED LANGUAGE:** _____
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/day 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: (reason and date)

_____
_____
_____

LIST ANY 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(date) _____ Influenza(date) _____ Zostavax (date) _____
Pneumovax (Pneumonia) (date) _____ Prevnar13 (Pneumonia) (date) _____

SOCIAL HISTORY: Tobacco Use (please circle one): Never Cigarettes Quit Date _____
Current Smoker: packs/day _____ # of years: _____ Interested in quitting? Yes / No
Other Tobacco: *Pipe* *Cigar* *Chew*
Alcohol Use: Do you drink alcohol? No / Yes, # of drinks/week _____
Is alcohol use a concern for you or others? No / Yes
Illicit Drug use? No / 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, What kind of Exercise?

_____
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.

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

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, I understand that if I show up late to my appointment, I may have to reschedule to the next available appointment because we value your time as well as the rest of our patients' time.

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 _____

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:_____
[ ] Other_____Phone:_____
[ ] Information is not to be released to anyone.

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

Notice of Privacy Practices

A copy of Peak Health Family Medicine's (PHFM) Notice of Privacy Practices (NPP) is available to you if requested.

Please check one of the following boxes below:

[ ]I have been provided a copy of PHFM's NPP today, upon my request (please see our receptionist and he/she will promptly provide you with a copy)

[ ]I will not take a copy of PHFM's NPP today but am aware that it is posted clearly at the front desk and online for review, and is available to me if I request a copy in the future.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] 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: _____

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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