



phone: 720.898.1110 | fax: 720.898.1113
www.sfmcolorado.com

NAME OF PATIENT: _____
PATIENT ADDRESS: _____ APT # _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE NUMBER: _____ DATE OF BIRTH: _____
CELL PHONE NUMBER: _____ SOCIAL SECURITY NUMBER: _____
SEX: _____ MARITAL STATUS: _____
EMPLOYER NAME: _____ WORK PHONE NUMBER: _____
EMPLOYER ADDRESS: _____
OCCUPATION: _____
EMAIL: _____ HOW DID YOU HEAR ABOUT US? _____
PREFERRED PHARMACY _____ LOCATION _____

RESPONSIBLE PERSON INFORMATION (NAME THE INSURANCE IS UNDER)

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE NUMBER: _____ WORK PHONE NUMBER: _____
DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
NAME OF EMPLOYER: _____
EMPLOYER ADDRESS: _____

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFO

INSURANCE NAME: _____	_____
POLICY / ID NUMBER: _____	_____
GROUP NUMBER: _____	_____
POLICY HOLDER NAME: _____	_____
COPAYMENT AMOUNT: _____	_____

EMERGENCY CONTACT INFORMATION

NAME: _____
RELATIONSHIP: _____ PHONE NUMBER: _____

I hereby authorize payment directly to Sports and Family Medicine of Colorado, PC and authorize the release of any medical information to process insurance claims.

I voluntarily consent to examination and treatment for myself and/or my dependent.

I will be responsible for the full amount of the charges except those under Sports and Family Medicine of Colorado PC's contractual arrangements with payors.

SIGNATURE OF RESPONSIBLE PERSON: _____

DATE: _____



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Sports and Family Medicine of Colorado, P.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Sports and Family Medicine of Colorado to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Sports and Family Medicine of Colorado describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Sports and Family Medicine of Colorado 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 Sports and Family Medicine of Colorado, 6390 Gardenia Street, Suite #140, Arvada, CO 80004.

With this consent, Sports and Family Medicine of Colorado may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Sports and Family Medicine of Colorado may mail to my home or other alternative 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."

With this consent, Sports and Family Medicine of Colorado may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Sports and Family Medicine of Colorado restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Sports and Family Medicine of Colorado to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Sports and Family Medicine of Colorado may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable



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To the patients of Sports and Family Medicine of Colorado

Appointment Scheduling

In order to improve our quality of service, we are looking at ways of reducing waiting time for your appointment.

There are frequently unforeseen complications in medicine that preclude any permanent solution. There are some simple steps that you can take that will help reduce the wait time for all patients.

When you are scheduling appointments, please notify the scheduling staff of all medical issues you would like to discuss. To adequately address these issues, we must allow the right amount of time. This helps us stick to our schedule and see all of our patients in a timely fashion. We may need to schedule more than one office visit for multiple problems. Please notify the office at least *24 hours in advance* if you will need to cancel or reschedule your appointment, for any reason. That way, patients with an unforeseen illness or injury can be seen as soon as possible. Patients that have scheduled an appointment and do not notify the office in advance that they will need to cancel will be assessed a **\$25.00 “no show” fee**.

Please bring a list of all your medications to each visit. This list should include the name of the medication, dose and frequency and should be presented at the beginning of your visit. Better yet, place all your pill bottles in one bag and just bring the bag.

Having additional family members seen during your scheduled visit is generally not possible. Trying to accommodate this request increases the wait time for other scheduled patients.

Financial

You will be asked to provide your insurance card at each visit. Patients are responsible for knowing the benefits of their insurance policies. If you have questions, please call the member services number listed on your card prior to your appointment. You will also be asked on each visit to verify that your address, phone numbers and insurance information is unchanged from your last visit.

Patients without insurance, or who have insurance with a plan that we do not participate with, will be required to pay in full for all charges at the time of service. Please ask about our cash discount. Patients that do not pay their co-pay at the time of their appointment will be assessed a **billing fee of \$15.00**.

If you are covered by an insurance plan that we do participate with, we will bill your insurance as a courtesy to you. Regardless of insurance coverage, you are responsible for all charges incurred during your office visit. Our billing cycle is monthly. Balance is due upon receipt and no later than 90 days. Account balances past 120 days will go to collections and lead to patient dismissal. Please understand that a **monthly billing fee of \$15.00** will be assessed on any unpaid balance.

If lab work is done during your visit, you will receive a separate bill from the laboratory that handles that work. Any billing questions regarding lab bills will need to be dealt with directly with the lab. We have nothing to do with their billing.

Thank you for your assistance. By following these guidelines you will be helping us improve the quality of care our patients receive.

Signature: _____ have read and agree to abide by the preceding policies, terms and conditions of Sports and Family Medicine of Colorado.



HEALTH HISTORY FORM

Date: _____

Name: _____

Birth date: _____

Marital Status: Single Married Separated Divorced Widowed Other

Education Level: Grade School High School College Advanced Degree

Occupation: _____ Please describe work: _____

Hobbies: _____

Medication Allergies (include reaction): _____

Current Medications and Dosage (include non-prescription):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Hospitalizations/Surgeries:

Date:	Reason/Event

NAME: _____

DOB: _____

Family History:

	AGE (or age at death)	Medical Conditions or Cause of Death
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
	_____	_____
Sisters	_____	_____
	_____	_____
	_____	_____

Immunization History:

When did you last have these immunizations?

Tetanus _____

Pneumonia _____

Hepatitis B _____

Has any family member had:

YES	NO		YES	NO	
		Cancer of the breast			Heart disease
		Cancer of the colon			Depression
		Cancer of the prostate			Other mental illness
		High blood pressure			Alcoholism
		Diabetes			

Health Risks:

YES	NO	
		Do you smoke? If yes, how many packs per week?
		Do you chew tobacco?
		If you drink alcohol, how much? what type?
		Have you ever used intravenous drugs or received a blood transfusion?
		Are you concerned about your risk of HIV (AIDS)?
		If you ride a bicycle or motorcycle, do you wear a helmet?
		Do you use seatbelts regularly?
		Do you use sunscreen most of the time?
		Does your home have a smoke alarm?
		Do you exercise often? If yes, how often? what type?

Name: _____

Date: _____

Occupation: _____ Height: _____

Weight: _____ Age _____

1. Reason for visit: _____
2. How long have you had problem? _____
3. Was the onset **gradual** or **sudden** (please circle)? **GRADUAL** **SUDDEN**
4. Did you have an **injury**? **YES** **NO** Date of injury _____
What happened? _____
5. If you have pain, where is it located? _____
6. Describe the pain (please circle): sharp dull electric burning throbbing
7. Do you have any of the following symptoms? (please circle)
Clicking popping locking swelling giving way weakness
numbness/tingling dislocation stiffness looseness of joint
8. How bad is the pain on a scale of 1 - 10 (0 = no pain, 10 = worst pain possible)? _____
9. Do you have pain at night? **YES or NO**
10. What makes your problem **worse**? _____
11. What makes your problem **better**? _____
12. What does your problem limit you from doing? _____
13. Is your problem? Getting **better** getting **worse** staying the **same**
14. Have you had physical therapy? **YES or NO** Did it help? **YES or NO**
15. Have you had injections? **YES or NO** Did they help? **YES or NO**
16. Were you given medicines? **YES or NO** What medicine? _____
17. Did the medicine help? **YES or NO**