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.

Physical Exam Information

What does a physical exam typically entail?

- The complete physical, or periodic health examination, should answer one or more of the following questions: (1) "Am I in the early stages of a disease that, if detected, can be cured or forestalled?" (2) "Are there lifestyle changes I can make that will improve my health and well-being?" (3) "Can I get information about my specific health concerns?" *
- The above will often be accomplished with a *comprehensive history and physical exam*
- Labwork may be indicated based upon the above
- Multiple medical problems may be *identified and often a follow up office visit* will be required to go into more detail and focus in these areas

Why can't the health care provider address every problem at the time of the physical?

- Many times the health care provider *would like to* do this because it is *more efficient* for you and for us. However, schedule constraints and **insurance limitations** often prevent this.
- Often times the health care provider will try to accommodate additional concerns at the time of the physical, but this *may result in an additional co-payment fee or charges that get applied to a deductible.*

As always, we try to do our best to effectively and efficiently manage your healthcare. If you have questions or concerns regarding the above, please review with your health care provider.

I have read and understand the above.

____
Signature of Patient or Legal Guardian Printed Name

____
Date

* American Academy of Family Practice

ADULT 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 Dosing (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 or	________________	____
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?
		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?

NAME:_________________________________ **DOB**:______________________________

Symptoms or Concerns:

YES	NO	
		Any skin problems?
		Any suspicious skin lesions?
		Any eye problems?
		Glaucoma or persistent eye pain?
		Wear contact lenses or glasses?
		Any hearing or ear problems?
		Frequent nose bleeds, recurrent sinus pain or congestion?
		Any dental disease or wear dentures?
		Any trouble breathing, shortness or breath, chronic cough?
		Any unusual hoarseness?
		Ever exposed to tuberculosis or have positive skin test or chest x-ray?
		Any heart problems?
		Do you develop chest pain with exertion?
		Frequent swelling of feet?
		Ever blood clots in legs or lungs?
		Ever rheumatic fever?
		Does walking cause pain in the legs?
		Any problems with digestion or movements?
		Difficulty swallowing?
		Heartburn or nausea?
		Ever had an ulcer?
		Any problems with urination?
		Trouble emptying bladder, leaking urine?
		Ever have a kidney stone?
		Any arthritis or joint pain? Where?
		Recurrent back problems?
		Other bone or joint problems?
		Troubled by headaches?
		Ever lost consciousness or had seizure?
		Any trouble sleeping?
		Difficulty concentrating?
		Troubled by depression?
		In the last year, any unexplained change in weight?
		Unusual heat or cold sensitivity?
		Ever a thyroid problem?

NAME:_______________________________ **DOB**:____________________________

QUESTIONS FOR MEN ONLY:

YES	NO	
		Any lumps or pain of the testicles?
		Any problems with erections or sexual intercourse?
		Ever any sexually transmitted diseases?
		Ever have same-sex sexual activity?
		Any questions about when or how to examine your testicles?

QUESTIONS FOR WOMEN ONLY:

How many times pregnant?__________________ How many children?______________________

What method of contraception do you use?____

Any lumps, pain, discharge or skin changes of the breast?_______________________________

Any questions about when or how to examine your own breasts?__________________________

Any problems with menstrual cycles?______________________

Age at onset _______________ years old. Length (from start to start)________________

Usual duration of flow ______ days. Date of start of last flow_____________________

Date of last Pap smear ______________________ Ever an abnormal Pap?___________________________

Did your mother take DES when pregnant with you?___________________________________

Ever any pelvic or vaginal infections?____

Any usual vaginal discharge or itching?____

Any prior sexually transmitted diseases? Yes________ No_________

Any symptoms of menopause? Yes________ No_________

QUESTIONS FOR THE ELDERLY:

YES	NO	
		Have you fallen lately?
		Would you like to discuss a living will?