

**ADOLESCENT HEALTH HISTORY QUESTIONNAIRE (age 13-17yo)**

**Name:** \_\_\_\_\_

**Family Information:**

People you live with, and their relationship: \_\_\_\_\_  
\_\_\_\_\_

Parents' marital status: \_\_\_\_\_

If separated or divorced:

Do you see both of your parents? Yes No Who do you live with most often? \_\_\_\_\_

Please list the names and phone numbers of both parents (if applicable)

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Allergies to medications (please circle):** Yes None Known If yes, please list medication(s) and type of reaction:

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**Medications:** (Please list any medications you currently take, including doses, frequency, etc. Please include any vitamins or supplements)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health History:**

Were you born prematurely? Yes No Any developmental problems? Yes No

Please list any current medical problems, including when diagnosed:

\_\_\_\_\_  
\_\_\_\_\_

Any Hospitalizations? (please circle) Yes No Details: \_\_\_\_\_

Any surgeries (please circle)? Yes No Details: \_\_\_\_\_

Please list any other conditions you've seen a doctor for more than once or twice? (i.e. frequent ear infections, asthma, etc)

\_\_\_\_\_  
\_\_\_\_\_

Do you see any other doctor on a regular basis? Yes No Details: \_\_\_\_\_

When was your last: Full physical exam: \_\_\_\_\_ Tetanus shot (year): \_\_\_\_\_

**Family History**

<b>PROBLEM</b>	<b>FAMILY RELATION</b>	<b>DESCRIBE ANY DETAILS</b>	<b>AGE OF DEATH (IF APPLIES)</b>
High blood pressure			
High cholesterol			
Heart attack (age occurred)			
Other heart disease Asthma, other lung problems			
Stroke			
Blood clots/bleeding disorder			
Migraines/other neurologic			
Cancer (list type)			
Colon Polyps			
Diabetes			
Thyroid disease			
Cancer (list type)			
Depression or other psych			
Alcoholism/Drug Abuse			
Other (explain)			

**Social History:**

Are you in school (please circle)? Yes No

If yes, what school do you attend? \_\_\_\_\_ What grade are you in? \_\_\_\_\_

Do you have a job? Yes No Details: \_\_\_\_\_

Do you get regular exercise? Yes No Play sports? Yes No Details: \_\_\_\_\_

What do you like to do in your free time? \_\_\_\_\_

Do you feel that you are (please circle): Underweight Overweight Just right

Do you diet on a regular basis? Yes No

**Questions for females):**

Have you started your period yet (please circle)? Yes No

If yes, how old were you when you had your first period? \_\_\_\_\_ Any problems with your periods? \_\_\_\_\_

## **PATIENT REGISTRATION**

### **PATIENT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: H: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

DOB: \_\_\_\_\_ SS: \_\_\_\_\_ Sex: F M

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph: \_\_\_\_\_

### **GUARANTOR:**

Person responsible for the bill: Self Spouse Parent Other

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: H: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

DOB: \_\_\_\_\_ SS: \_\_\_\_\_ Employer: \_\_\_\_\_

### **INSURANCE INFORMATION:**

Insurance Company:

\_\_\_\_\_

Patient ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Claims Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Family Medicine at Lowry**  
**Practice Policy & Procedures**

Just as we are dedicated to providing you with the best possible medical care, we are also committed to extending this same level of service to our business and financial policies. It is crucial that you understand these policies, especially in view of the ongoing changes in the health care industry. These changes may affect you in the services that are covered by your insurance carrier or in the services that are determined by insurance to be due and payable directly to you.

**Financial Responsibility**

I hereby accept responsibility for all charges incurred for treatment that is not covered by my insurance. I agree to responsible attorney and/or collection agency fees if my account is turned over to an attorney and/or collection agency for collection. I understand I must furnish a copy of my insurance card(s) and a valid ID or I will be responsible for payment of all charges.

**COLLECTIONS INFORMATION:** Your insurance company will notify both you and our office with an EOB (explanation of benefits) if there is a balance due that is your responsibility. Balances over 30 days will incur a 2% interest charge per month. Accounts that have gone beyond 60 days will be considered delinquent and it will be in everyone's best interest to send this account to an outside collection agency. Your balance to them will also include a \$25 fee for their processing charge.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Co-Payment Policy (if applicable)**

Per insurance laws and regulations, all patients are expected to pay their co-pay at the time of the office visit. Most insurance companies have co-payments, which is a flat fee per visit, and is a portion of the cost at the time the service is rendered. We will no longer bill for co-payments. In the event a bill is sent for the co-pay, an additional charge of \$15.00 to cover the cost of processing billing for you co-payment will be incurred. If you have any questions, comments or concerns, please contact the Office Manager.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

A photocopy of this authorization shall be as valid as the original from the initial date of completion. This consent is valid until specifically revoked in writing.

## **Cancellation/No-Show/Reschedule Policy**

The physicians at Family Medicine at Lowry are committed to providing quality care. If you are not present for your appointment, or cancel/reschedule with little notice, we are unable to fill that time slot and cannot run our office efficiently. Therefore, our policy requires that you give us at least 24 hours notice (not including weekends and holidays) if you need to cancel or reschedule your appointment. *Failure to show up for your appointment or a cancellation/reschedule less than 24 hours before the appointment, will result in the patient being billed \$100 for new patient and immigration appointments, and \$50 for existing patient appointments. Appointments will not be rescheduled until all fees have been paid. Also note, that if you are scheduled for a "same day" appointment, and cancel or no show, you will still be responsible for the \$50 cancellation fee. Thank you in advance for your cooperation.*

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<b>Print Name</b>	<b>Signature</b>	<b>Date</b>
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## **Late Arrival Policy**

Patient's that arrive 10 minutes or later for their scheduled appointment check in time will be asked to reschedule, and the reschedule fee described above will be applied. Please make every effort to arrive at the given check-in time to avoid any disruption in your care.

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<b>Print Name</b>	<b>Signature</b>	<b>Date</b>
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## **Prescription & Prescription Refill Policy**

Prescription Refills will be approved or denied within 72 hours of receipt. We receive hundreds of refill requests each day! The easiest and most efficient way to get the prescription refills you need is to CALL YOUR PHARMACY, even if your bottle says "no refills." The pharmacist will contact us directly for approval. From there, you simply have to visit your pharmacy, and pick up your refill. Please call several days BEFORE you run out of your medication. For medications such as BIRTH CONTROL, HORMONES, THYROID, and CHOLESTEROL that have 0 Refills, there may be a need to return to our office, BEFORE refills will be authorized. For NARCOTIC Prescriptions, you will be asked to visit our office for a hard copy of the prescription. In addition, you will be asked to sign a "pick up verification" slip.

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<b>Print Name</b>	<b>Signature</b>	<b>Date</b>
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**Patient Contact Information**

I understand that the office will at times need to get a hold of me during the day. I give permission to Family Medicine at Lowry **TO LEAVE DETAILS** regarding my care, test results, billing, or appointment reminders on a voicemail at the following number(s) in this order:

- 1. \_\_\_\_\_ **home work cell**
- 2. \_\_\_\_\_ **home work cell**
- 3. \_\_\_\_\_ **home work cell**

**I authorize Family Medicine at Lowry to *speak* with the following person(s) about my care:**

\_\_\_\_\_ Name \_\_\_\_\_ Relationship

\_\_\_\_\_ Name \_\_\_\_\_ Relationship

\_\_\_\_\_ Name \_\_\_\_\_ Relationship

**I understand that if I choose not to be contacted in one of these ways, I must prepare and present written notice to Family Medicine at Lowry.**

\_\_\_\_\_ **Print Name**

\_\_\_\_\_ **Signature**

\_\_\_\_\_ **Date**

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**Family Medicine at Lowry**  
**HIPAA Policy**

I authorize the release of medical information necessary to process my insurance claim.

\_\_\_\_\_ (INITIAL)

I have reviewed this office's "Notice of Privacy Practices" which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I so request.

\_\_\_\_\_ (INITIAL)

**I have read and understand the HIPAA policy for Family Medicine at Lowry.**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

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