

ADULT HEALTH HISTORY QUESTIONNAIRE

Name: _____

Occupation: _____

Marital Status: _____

How did you hear about us? _____

**Members of your household
(and their relationship to you):** _____

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

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

Please list your current and past medical problems, including year diagnosed:

List all surgeries including dates:

List the names of medical specialists that you see:

Health Maintenance:

When was your last: General Physical: _____ Tetanus shot: _____ Colonoscopy/Flex sig _____

List any other vaccines you have had as an adult: _____

Questions for Women:

Mo/Yr of last pap: _____ Current method of birth control: _____

Have you ever had an abnormal pap smear? (list year and details): _____

If applicable: Mo/Yr of last mammogram: _____ Mo/Yr of last bone density: _____

Social History: (In order for us to be more sensitive to the needs of our patients, we ask the following):

Are your sexual relationships with (please circle): Men Women Both

Have you ever had a sexually transmitted disease? (if so, which?) _____

Have you ever experienced any physical, emotional or sexual abuse? Yes No

Smoking History: Do you smoke now? Yes No If yes: How many packs per day? _____

For how many years? _____ Are you ready to quit yet? _____

If you smoked previously:

When did you quit? _____

Other current tobacco use (cigars, chewing tobacco)? Yes No

Alcohol use (please circle): Never Rarely Socially Daily

Are you concerned about how much you drink? Yes No

Has anyone else ever mentioned they were concerned about your drinking? Yes No

Any use of illicit/street drugs? (please circle) Yes No Details: _____

Ever used IV drugs before? Yes No

Family History

PROBLEM	FAMILY RELATION	DESCRIBE ANY DETAILS	AGE OF DEATH (IF APPLIES)
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			
Bone or joint problems			
Depression or other psych			
Alcoholism/Drug Abuse			
Other (explain)			

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.***

Print Name	Signature	Date
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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.

Print Name	Signature	Date
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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.

Print Name	Signature	Date
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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**

_____ **Date**

_____ **Signature**

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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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