Sample Intake
April 2016

PATIENT REGISTRATION

Appointment Date: ________________

Patient's Last Name: _________________________ First: _________________________ DOB: _______________
Mailing Address: ___________________________________City:_______________State:______Zip:___________

☐ Male ☐ Female Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Email Address: ___________________________________ Employer Name _______________________________
Work Phone #: (_____) _____________Home Phone #: (_____) _____________Cell Phone #: (_____)

Insurance Information

Primary Insurance:_____________________Policyholder's Name:_________________Policyholder's DOB:________
Mailing address (if different from above):____
Policyholder's Employer_________________________Policyholder's Work Phone #: (______) ____________________
Policy # and Group #:____________________________Customer Service Phone #: (______) ____________________

Secondary Insurance:_________________Policyholder's Name:_________________Policyholder's DOB:__________
Mailing Address (if different from above):____
Policy # and Group #:____________________________Customer Service Phone #: (______) ____________________

Please complete this section if patient is a minor (if patient is under the age of 18) Responsible Party
Name:____DOB:_______________________________________
Relationship to Patient:______________________________ Primary Phone #: (______) _______________________
Address:__________________________________ City:________________State:__________Zip Code:_____________

Emergency Contact
In case of an emergency, contact:______________________________ Phone #: (______) _______________________
Relationship to patient:____

Insurance Authorization and Assignment of Benefits: I hereby authorize payment directly to ACC Physicians and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance. I voluntarily consent to treatment for myself and/or dependents. I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payor and/or not paid to ACC Physicians. Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs. I further understand that a monthly finance charge of .5% (6 % annually) will be assessed on any unpaid balance.

Patient/Guardian Signature:____ **Date:** ________________________
(If patient is a minor, parent/legal guardian must sign on their behalf)

Relationship to patient: ____

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ADULT HEALTH HISTORY FORM

Patient Name: ______________________ **Today's Date:** ________________________

Date of Birth: ______/_______/________ **Reason for Visit:** ______________________

Occupation: ________________________ **Marital Status:** ________________________

PERSONAL HEALTH HISTORY/ CHRONIC MEDICAL PROBLEMS (*list all that apply*)

HEALTH MAINTENANCE (*If known, list the most recent date (month and year) for all that apply Ex: January, 2014). Date typing help: Type the three-letter abbreviation for the month, the four-digit year, and hit tab. The correctly formatted date will appear on the form.*
NEW PATIENTS: Please bring a copy of your vaccination records

WOMEN ONLY:	BOTH MEN AND WOMEN:		MEN ONLY:
Menstrual Period (start date):	Flu Shot:	Pneumonia Vaccine:	Digital Rectal Exam:
Last Pap Smear (date): Last Abnormal Pap (date):	Tetanus Booster:	Hepatitis B Vaccine:	PSA (Prostate Blood Test):
Mammogram:	Zostavax Vaccine:	Bone Density (DEXA):	
Number of Children:	HgA1c (if diabetic):	Eye Exam:	
Number of Pregnancies:	Colonoscopy:		

CURRENT MEDICATION (*please include non-prescription OTC and herbal supplements including marijuana*)	**DOSE AND STRENGTH**

Allergies	**Reaction**

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PREVIOUS HOSPITALIZATIONS/SURGERY/ MAJOR TRAUMA (*not including normal births*)	**DATE & LOCATION**

FAMILY HISTORY Please indicate if any family members (parents, sibling, grandparents) have the following conditions. Use the following abbreviations to illustrate who.
M=Mother; **F**=Father; **S**=Sister; **B**=Brother; **MGM**= Maternal Grandmother; **MGF**=Maternal Grandfather; **PGM**=Paternal Grandmother; **PGF**= Paternal Grandfather; **O**= Other

Yes	**Who**	**Condition**	**Yes**	**Who**	**Condition**
		Diabetes			Lung Cancer
		Heart Disease			Alcoholism
		High Cholesterol			Mental Health
		Cervical Cancer			High Blood Pressure
		Breast Cancer			Skin Cancer
		Colon Cancer			Prostate Cancer

SOCIAL HISTORY (*choose "Yes" or "No"*)	**IF "Yes", HOW OFTEN OR WHEN?**
Do you consume alcohol?	
Do you use Marijuana?	
Do you use Tobacco Products?	
If you answered "Yes" to any of the above, are you interested in quitting?	
Did you recently quit any of the above? When?	
How often do you exercise?	

ADULTS 65 AND OVER	**DETAILS**
Have you fallen lately?	
Do you have an advance directive?	

LIST OTHER HEALTHCARE PROVIDERS AND THEIR SPECIALTY

PREFFERED PHARMACY (Name and City):

ADDITIONAL INFORMATION & CONTINUATIONS:

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Patient Name: ________________________ **Date of Birth:** ______/_______/____________

	REVIEW OF SYMPTOMS *please check all that you are* ***currently*** *experiencing*			
General	☐ Fever	☐ Chills	☐ Recent Weight Loss or Gain	☐ Fatigue/Tired
Eyes	☐ Eye Pain	☐ Eye Discharge	☐ Eye Itch	☐ Eyesight Problems
Ear Nose Throat (ENT)	☐ Earache ☐ Loss of Hearing	☐ Hoarseness ☐ Nasal Discharge	☐ Nosebleeds	☐ Sore Throat
Heart	☐ Pain in Chest	☐ Palpitations	☐ Heart Rate Fast ☐ Heart Rate Slow	☐ Cramping in lower leg
Lungs	☐ Cough	☐ Shortness of Breath (SOB)	☐ Wheezing	☐ Coughing at Night
Gastrointestinal	☐ Abdominal Pain ☐ Heartburn	☐ Constipation ☐ Vomiting	☐ Diarrhea	☐ Dark Stool or Blood in Stool (melena)
Genitourinary	☐ Pelvic Pain ☐ Pelvic or Vaginal Infection ☐ Lumps or pain in testicles	☐ Incontinence ☐ Dysuria (pain while urinating) ☐ Difficult in urinating	☐ Nocturia (waking up at night to urinate) ☐ Vaginal Discharge ☐ Problems with Menstrual Cycle	☐ Abnormal Vaginal Bleeding ☐ Abnormal Pap Smear
Orthopedic	☐ Joint/Limb Pain	☐ Difficulty walking or standing	☐ Joint Stiffness	☐ Swelling in Limb
Skin	☐ Skin Lesions	☐ Change in Mole	☐ Itching ☐ Genital Lesions	☐ Breast Lump ☐ Breast Pain
Neuro/Psych	☐ Dizziness ☐ Anxiety	☐ Confusion ☐ Emotional Problems	☐ Limb Weakness ☐ Sleep Disturbances	☐ Fainting ☐ Tripping/Falling
Endocrine	☐ Hot Flashes	☐ Muscle Weakness	☐ Bulging of Eye (Proptosis)	☐ Deepening of Voice
Blood and Lymph	☐ Easy Bruising	☐ Easy Bleeding	☐ Swollen Glands	
ADDITIONAL INFORMATION OTHER				

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature: ______________________________________ **Date:** ____________________________

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Transfer of Medical Records

PATIENT INFORMATION – PLEASE PRINT

Name: ____________________________________

Date of Birth: ________________________________

Phone Number: _______________________________

RELEASE FROM:

Name: ___________________________

Address: ___________________________

____

Phone: ____________________________

Fax: ______________________________

RELEASE TO:

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Fax: ________________________________

I request and authorize this transfer and release of my medical record to and from the medical practices listed above. I understand that this documentation includes all forms of Protected Health Information (PHI) and is also applicable to the electronic transfer of records if the requested recipient is able to accept and access encrypted information from the ACC Physicians Electronic Medical Record.

- ☐ **ENTIRE RECORD - OR:**
- ☐ **Doctor's Notes**
- ☐ **Pathology Reports**
- ☐ **X-Ray Reports**
- ☐ **Laboratory Reports**
- ☐ **Diagnostic Studies**
- ☐ **Third Party Record**
- ☐ **Medications**
- ☐ **Diagnoses**
- ☐ **Other**_______________

Due to the sensitivity of the following information please check off and initial if you would like the following information to be released:

- ☐ Notes and reports related to STDs including HIV/AIDS ________ (initial)
- ☐ Psychiatry/Mental Health Notes ________ (initial)
- ☐ Notes related to Drug/Alcohol Abuse ________ (initial)

I understand that ACC Physicians will no longer be responsible for the protection of the PHI except in its original format in their records. The recipient of the medical records becomes responsible for the protection of the PHI once the transfer takes place.
I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present the written revocation to the Site Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I certify that this request has been made voluntarily.

(**Please Note: There may be a charge for the copying of records**)

In Accordance with Chapter 2, Part 5, sections 5.2.3.4 of the Colorado Regulations of Health Facilities, the cost of this information cannot exceed $16.50 for the first 10 or fewer pages and $.75 per page for pages 11 through 40, and $.50 per page after 40 pages. Actual postage or shipping costs and applicable sales tax, if any, may be charged. We will not be able to process your request until the following payment is received.

______________________________ ______________________________
Signature of patient Date

______________________________ ______________________________
Witness

____
Signature of Authorized Representative (If patient is a minor or unable to sign) – Attach Copy of Durable Power of Attorney if patient is an adult

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RELEASE OF MEDICAL INFORMATION CONSENT FORM

Patient Name: ____________________________________**Date of Birth**: ____________________________

At times ACC Physicians may need to contact you. By filling out the information below we will better be able to serve you. If you want to allow us to leave messages and/or to speak with a trusted individual regarding your medical care we need written authorization in order to do so.

Please indicate if we have your permission or not to leave phone messages regarding your medical care:

☐ I authorize ACC Physicians to leave phone messages containing my Personal Health Information on the following telephone numbers (s):

Phone Number: _____________________________Phone Number: ___________________________

☐ No, I do not authorize ACC Physicians to leave phone messages containing Personal Health Information on any of my telephone number (s).

☐ I authorize the release of any and/or all of my Personal Health Information (PHI) to the person (s) listed below. These individuals are family and/or trusted friends that ACC Physicians has my permission to share my medical care, test results, treatment and billing matters with upon **their** verbal or written request. You also have my permission to leave a telephone message directly with the person(s) and telephone numbers listed below. I understand that by leaving this section blank, it indicates that I do not grant permission for ACC Physicians to speak with a family and/or trusted friend.

Name: __________________________________ Relationship: ______________ Phone: _________________

Name: __________________________________ Relationship _______________Phone: __________________

Name: __________________________________ Relationship _______________Phone: __________________

Name __________________________________ Relationship _______________ Phone: _________________

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present the written revocation to the Site Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I certify that this request has been made voluntarily.

Unless otherwise revoked, this authorization will not have an expiration date. ***I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.*** *I release ACC Physicians from any and all liability and claims of any nature pertaining to the disclosure of requested information once a disclosure takes place.*

____________________________________ __________________
Patient Signature Date

____
Witness

If patient is unable to sign, please document reason: