POTOMAC PRIMARY CARE

Patient Information

Date:______________________ Email:____

Permission to contact via Email ❑Yes ❑No

First Name:_______________________________________M.I.________Last Name:____________________________________

Address:____Apt/Unit#_______________________

City:_________________________State:___________Zip Code:_______________Home Phone:(_____)____________________

Date of Birth:_______/_______/_______ SS# _____________ ________ _______________

Primary Care Physician:____ Number:(_____)_____________________

Pharmacy:____ Number:(_____)_____________________

Emergency Contact

Name:___________________________Relationship:______________Emergency Phone Number (_____)___________________

Guarantor Information

(Responsible Party Information)

First Name:_______________________________________M.I.________Last Name:____________________________________

Address:____Apt/Unit#_______________________

City:_________________________State:___________Zip Code:_______________Home Phone:(_____)____________________

Primary Insurance Information

(Please provide your insurance car to receptionist to copy)

Effective Date:________________________Insurance Name:____

Insurance Claims Address:____

Address:____Apt/Unit#_______________________

City:____________________________State:__________Zip Code:_____________Phone Number:(_____)___________________

Group#________________________Insurance ID or Policy #:__________________________________Copay:_________________

Policyholder's Name:_________________________________Policyholder's Relationship to Patient:_____________________

Address:____Apt/Unit#_______________________

City:____________________________State:____________Zip Code:______________Home Phone:(_____)__________________

Policyholder's Date of Birth:_________________Sex: ❑Male ❑Female Social Security #______________________________

Policyholder's Employer:____Work Phone:(_____)________________

Secondary Insurance Information

Effective Date:________________________Insurance Name:____

Insurance Claims Address:____

Address:____Apt/Unit#_______________________

City:____________________________State:__________Zip Code:_____________Phone Number:(_____)___________________

Group#________________________Insurance ID or Policy #:__________________________________Copay:_________________

Policyholder's Name:_________________________________Policyholder's Relationship to Patient:_____________________

Address:____Apt/Unit#_______________________

City:____________________________State:____________Zip Code:______________Home Phone:(_____)__________________

Policyholder's Date of Birth:_________________Sex: ❑Male ❑Female Social Security #______________________________

Policyholder's Employer:____Work Phone:(_____)________________

Accident Information (If applicable)

Date of Accident:___________________ Circle One: Auto Related ❑ Work Related❑ Sports Related ❑ Other❑

Insurance Claim #(if known)_____________________________Claim Adjustor Name_____________________________

HOW DID YOU LEARN ABOUT US?

❑Referring Provider ❑Website ❑HealthGrades.com

❑Other____

❑Family/Friends ❑Blog ❑Vitals.com

❑Search Engine ❑Facebook ❑Yelp.com

❑Physician Directory ❑Twitter ❑Google Places Page

How Can We Reach You?

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

Name (Please Print):____

Home Phone Number:____

Cell Phone Number:____

Work Phone Number:____

HealthOne Clinic Services

Phone Message Consent

In effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will ***NOT*** leave messages with anyone except the patient or legal guardian.
- We will ***NOT*** leave any confidential information on an answering machine.
- We will ***NOT*** leave any message on voicemail.

Unless

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your medical care.

I,________________________________give HealthOne my permission to speak with and/or leave phone messages regarding my meical care and/or billing concerns/questions with the following. I fully understand that this consent will remain valid until revoked in writing.

My home answering machine: Initials__________ My work voice mail: Initials__________
My celluar voice mail: Initials__________ My spouse/guardian: Initials__________
Other:____________________ Phone Number:_____________________________ Initials__________

EMERGENCY CONTACT:

Name:____Phone Number:_______________________________
Initials________________

Signature:____
Date:____

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician or facility to provide records: ____Phone # _____________________________

Patient's name: ____

Address: ____

Social Security #: _____________________________________ DOB: ____

Records to be received by: Please Do Not Fax Records

Potomac Primary Care
1400 South Potomac Street #190
Aurora, CO 80012
Phone 720-979-0836
Fax 303-369-1919

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

_____Drug Abuse (if any) Substance Abuse (if any) _____

_____Psychological or psychiatric conditions (if any) AIDS/HIV status (if any) _____

Release these records:

1. Only records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at facility (specify below) _____
3. All medical records at this facility _____

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print): Person authorized to sign for patient:

____________________________ __________________________

Patient's signature:

____________________________ Date: _____________________

PATIENT HEALTH HISTORY

Date: ____________________________

Name: ____

D.O.B.: ____

REASON FOR TODAY'S VISIT:

____

CURRENT PRESCRIPTION MEDICATIONS:

____

OVER THE COUNTER MEDICATIONS AND SUPPLIMENTS:

____

CURRENT MEDICAL PROBLEMS:

____

MEDICAL HISTORY:

____

SURGICAL HISTORY:

____

ALLERGIES:

HAVE YOU EVER BEEN TOLD YOU'VE BEEN TREATED FOR ANY OF THE FOLLOWING?

- ❑ High Cholesterol
- ❑ High Triglycerides
- ❑ High Blood Sugar
- ❑ Abnormal Liver Tests
- ❑ Abnormal Kidney Tests
- ❑ Atherosclerosis
- ❑ Heart Disease
- ❑ Cancer
- ❑ Asthma
- ❑ Depression/Anxiety
- ❑ Thyroid Disease
- ❑ Other____

FAMILY HISTORY: Have your parents, siblings, or grandparents had any of the following:

- ❑ Colon Cancer
- ❑ Breast Cancer
- ❑ Prostate Cancer
- ❑ Other Cancer: ____
- ❑ Heart Attack
- ❑ Diabetes
- ❑ Other Heart Disease: __________________________
- ❑ Other: ____________________________________

Has a family member died less than 50 years of age?

____

____

TELL US HOW YOU'RE DOING

Have you had any of the following symptoms on a frequent or recurring basis in the last few months?

❑YES ❑NO Unexplained weight loss or weight gain

❑YES ❑NO Fever or chills

❑YES ❑NO Headaches

❑YES ❑NO Dizziness or lightheadedness

❑YES ❑NO Blurred or double vision

❑YES ❑NO Red or itchy eyes

❑YES ❑NO Ear Aches, sore throat, runny nose or nasal congestion

❑YES ❑NO Palpations or Irregular heart beat

❑YES ❑NO Chest Pain

❑YES ❑NO Cough, shortness of breath, wheezing

❑YES ❑NO Heartburn

❑YES ❑NO Nausea or vomiting

❑YES ❑NO Constipation, diarrhea or rectal bleeding

❑YES ❑NO Urinary frequency or burning with urination

❑YES ❑NO Rash

❑YES ❑NO Depression or anxiety

❑YES ❑NO Frequent infections

❑YES ❑NO Back Pain or Joint Pain

❑YES ❑NO Bruising or Bleeding

When was your last (Please provide dates): Normal Abnormal

Pap Smear________________________________ ❑ ❑

Mammogram_____________________________ ❑ ❑

Colonoscopy______________________________ ❑ ❑

Prostate Check Up_________________________ ❑ ❑

Dental Visit_______________________________

Eye Exam_________________________________

Do you eat a healthy diet? ____

How many times per week do you exercise?

____

Do you practice safe sex? ____

What is your sexual preference? ____

Are your immunizations up to date? ❑FLU ❑PNEUMONIA ❑TETANUS ❑SHINGLES

Do you smoke or chew? ❑ No ❑Yes, if so how much per day?

____

Other Drugs? ❑ No ❑Yes, if so how much per day?

____

Alcohol Intake: ❑ No ❑Yes

Have you had more than 5 drinks in a day in the past 6 months? Yes ___ No ___

Have you been hospitalized for Mental/Emotional Reasons?

____

____

Have you been under more stress than usual lately?

____