# DR. WILLARD'S FAMILY PRACTICE

## NEW PATIENT HISTORY

Name _____ Age _____ Today's Date _____

Birth Date _____ Social Security Number _____

Occupation _____ [ ] Single [ ] Married [ ] Divorced [ ] Widow(er)

Date of Last Tetanus _____ Date of Last Physical _____

Medication _____

_____

_____

| | Age | Health | If Deceased Age at Death | Cause of Death | Have any Blood Relatives [X] Had | Who |
|---|---|---|---|---|---|---|
| Father | | | | | [ ] Cancer | |
| Mother | | | | | [ ] TB | |
| Brothers 1 | | | | | [ ] Diabetes | |
| OR 2 | | | | | [ ] Heart Trouble | |
| Sisters 3 | | | | | [ ] High BP | |
| 4 | | | | | [ ] Stroke | |
| 5 | | | | | [ ] Epilepsy | |
| Spouse | | | | | [ ] Insanity | |
| Children 1 | | | | | [ ] Suicide | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

### Social History

Tobacco use [ ] No [ ] Yes
How long? _____
How much? _____

Alcohol Consumption [ ] No
[ ] Yes

Drinks per week? _____

Pets in house [ ] No [ ] Yes

Do you provide seat belts for yourself and your children [ ] No [ ] Yes

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorize us to do so.

### Gynecological History

How many pregnancies? _____
How many births? _____

Age menstruation started? _____
Age menopause? _____

Any bleeding since menopause? _____

Are you having any problems currently? _____

_____

_____

**Illnesses**
Check any you have ever had:

[ ] Measles
[ ] German Measles
[ ] Mumps
[ ] Chicken Pox
[ ] Whooping Cough
[ ] Scarlet fever or Scarlentina
[ ] Diphtheria
[ ] Small pox
[ ] Pneumonia
[ ] Influenza
[ ] Pleurisy
[ ] Rheumatic fever or heart disease
[ ] Arthritis or Rheumatism
[ ] Any bone or joint disease
[ ] Neuritis or neuralgia
[ ] Bursitis, Sciatica or Lumbago
[ ] Polio or Meningitis
[ ] Nephritis
[ ] Gonorrhea or Syphilis
[ ] Gallbladder disease
[ ] Anemia
[ ] Jaundice
[ ] Bladder disease
[ ] Epilepsy
[ ] Migraine headaches
[ ] Tuberculosis
[ ] Diabetes
[ ] Cancer
[ ] High or low blood pressure
[ ] Colitis or other bowel disease
[ ] Hemorrhoids or any rectal disease
[ ] Nervous breakdown
[ ] Food, chemical or drug poisoning
[ ] Hay fever or asthma
[ ] Hives or Eczema
[ ] Frequent infections
[ ] Any other disease

Have you been hospitalized for any illness?
[ ] No [ ] Yes
Give Details:

_____
_____
_____
_____

**Allergies**
Are you allergic to:

[ ] Penicillin or Sulfa
[ ] Aspirin, Codeine or Morphine
[ ] Mycins or other antibiotics
[ ] Merthlolate or Mercurochrome
[ ] Any other drug
[ ] Any foods
[ ] Adhesive tape
[ ] Nail polish or other cosmetics
[ ] Tetanus Antitoxin or serums

**Injuries**
Have you had any:

[ ] Broken or cracked bones
[ ] Sprains
[ ] Lacerations
[ ] Dislocations
[ ] Concussion or head injury
[ ] Ever been knocked unconscious

Weight
Now_____
One year ago_____
Maximum_____ When_____

**Transfusions**
Have you ever had:

[ ] Blood or Plasma transfusion

**Surgery**
Have you had:

[ ] Tonsillectomy
[ ] Appendectomy
[ ] Any other operation
Type_____ Year_____
Type_____ Year_____
Type_____ Year_____

Have you ever been advised to have any surgical operation which has not been done? [ ] No [ ] Yes
Give Details:

_____
_____
_____
_____

# DR. WILLARD'S FAMILY PRACTICE

## PATIENT INFO SHEET

**Patient Name:** _____

**Address:** _____ **Apt:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____

**Work Phone:** _____

**Cell Phone:** _____

Have any members of your family been seen in this office? _____

If yes, please list names _____

**(Please leave card out for office to make a copy.)**

Name of Insurance Company: _____

Group Number: _____

Billing Address on Insurance Card: _____

_____

Name of Insured: _____

Employer of Insured: _____

Insured S.S. #: _____

Insured Date of Birth: _____

**Emergency Contact -**

Name: _____

Phone Number: _____

# DR. WILLARD'S FAMILY PRACTICE

14100 E. Arapahoe Rd., #170
Englewood, CO 80112
(303) 699-3190

## MEDICAL QUESTIONAIRE

**Please answer the following questions:**

| | | **Date** |
|---|---|---|
| 1. | When was your last history and physical? | _____ |
| 2. | When was your last tetanus vaccination? | _____ |
| 3. | When was your last flu vaccination? | _____ |
| 4. | When was your last pneumonia vaccination? | _____ |
| 5. | When was your last colonscopy? | _____ |
| 6. | When were your cholesterol levels checked last? | _____ |
| 7. | When did you last have a PSA level checked? (Male) | _____ |
| 8. | When did you have your last PAP? (Female) | _____ |
| 9. | When was your last mammogram? (Female) | _____ |

_____ _____

Patient Date Physician Date

**DR. WILLARD'S FAMILY PRACTICE, P.C.**
14100 E. Arapahoe Rd., #170
Englewood, CO 80112
(303) 699-3190 Fax (303) 699-3189

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Willard's Family Practice, P.C. 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 Dr. Willard's Family Practice, P.C., describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Willard's Family Practice, P.C. 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 the Office Manager, Dr. Willard's Family Practice, P.C., 14100 E. Araphahoe Rd., Ste., #170, Centennial, CO 80112.

With this consent, Dr. Willard's Family Practice, P.C. may call my home or other alterative 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, Dr. Willard's Family Practice, P.C. 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, Dr. Willard's Family Practice, P.C. 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 Dr. Willard's Family Practice, P.C. restricts 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 Dr. Willard's Family Practice, P.C. to use and disclose my PHI to carry out TPO.

I may revoke my consent to 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, Dr. Willard's Family Practice, P.C. may decline to provide treatment to me.

_____ _____
Print Patient's Name Date

_____ _____
Signature of Patient/Responsible Party Print Patient/Responsible Party

# DR. WILLARD'S FAMILY PRACTICE

## PAYMENT POLICY

Payment of services is due at the time services are rendered unless payment arrangements have been approved by our office manager. **We will bill your insurance IF you provide us with the necessary information. Please notify us immediately if your insurance coverage has changed.** If you fail to notify us of any change, you will be responsible for the services rendered. After thirty (30) days, your bill is considered past due, regardless of insurance coverage. At that time, you need to contact the office manager regarding a payment plan and regular monthly payments need to be started. If this is not done, your account will be sent to collections. **ALL co-payments are to be paid at the time of service.**

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. Your insurance is a contract exclusively between you, your employer & your insurance company. We are not a party to that contract. **Not all services are a covered benefit.** Some insurance companies arbitrarily select certain services they will not cover. .

**All charges are your responsibility** from the date the services are rendered. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Please be informed that if a **check is returned to us for insufficient funds,** your account will be assessed a **$25.00 service charge fee**. If for any reason your account has been forwarded to our collection service, you will be responsible for charges assessed to Dr. Willard for collection.

If you are unable to keep your scheduled appointment, please contact the office to cancel. By you not canceling a scheduled appointment, it is a waste of the doctor's time, as well as, uncourteous to other patients who need to be cared for and are unable to be fit into the schedule. **IF YOU DO NOT SHOW FOR YOUR SCHEDULED APPOINTMENT, YOU WILL BE ASSESSED A $50.00 FEE. IF YOU DO NOT SHOW FOR A PHYSICAL, YOU WILL BE ASSESSED A $100.00 FEE. Office protocol states that if you "No-Show" for three (3) or more appointments, you will not be rescheduled.**

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us.

I have read and understand the above information.

_____

Signature Date