The Family Practice

Please complete all the areas below if you are a new patient.
Please put your name and any changes if you are an established patient.

Name: ____

Address: ____

City: ____________________ State: __________ Zip Code: ____________

Gender: Male Female

Marital Status: Single Married Divorced Widowed

Language Preference: ____________________

Race: White Black Asian Indian/ Alaskan Pacific Isle Other/ Multi

*Social Security #: ____________________ *Date of Birth: /____/______

*Home #: ______________________________

*Cell #: ______________________________ Employer: ______________________________

*Email address: ____ or None

Legal Guardian (if applicable): ______________________________

*Emergency Contact: __________________________ Phone # : ______________________

*Relation: ______________________________

Head of Household: ____________________________ Date of Birth: /____/______

Other Family Members: Name Date of Birth

______________________________ ____/____/______

______________________________ ____/____/______

______________________________ ____/____/______

______________________________ ____/____/______

*Insurance Information

(if you have given your ins. card to the front desk, do not fill out this box)

Insurance Plan: ____________________ Policy# ____________________ Group# ____________

Address to send claims: ____

Policy Holder's Name: ______________________________

Secondary Ins and Address: ____

____

All patient information is kept confidential and secured. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Past Medical History

Name ________________________________ DOB ________________ Today's Date__________

Please circle your answer

ADD/ADHD: Yes or No

AIDS/HIV: Yes or No

Abuse/Domestic Violence: Yes or No

Allergies/Hayfever: Yes or No

Anemia : Yes or No

Anesthesia Complications: Yes or No

Anxiety Disorder: Yes or No

Arthritis: Yes or No

Asthma: Yes or No

Autism Spectrum Disorder (ASD): Yes or No

Bedwetting: Yes or No

Birth Defects or Inherited Disease: Yes or No

Bladder or Kidney Problems: Yes or No

Blood Diseases: Yes or No

Blood Transfusion: Yes or No

Breast Cancer: Yes or No

Breast Problem: Yes or No

Please circle your answer

Headaches : Yes or No

Heart Disease: Yes or No

Heart Problems: Yes or No

Hepatitis: Yes or No

High Cholesterol: Yes or No

Hospitalizations: Yes or No

Hypertension: Yes or No

Hyperthyroidism: Yes or No

Hypothyroidism: Yes or No

Infertility: Yes or No

Kidney Disease: Yes or No

Kidney Stones: Yes or No

Liver Disease: Yes or No

Lung Disease: Yes or No

MRSA exposure: Yes or No

Meniere's disease: Yes or No

Past Medical History

Name ______________________________ DOB _______________ Today's Date________

Please circle your answer		Please circle your answer	
COPD:	Yes or No	Mental Disorder:	Yes or No
Cancer:	Yes or No	Mental Illness:	Yes or No
Chicken Pox:	Yes or No	Muscle, Joint, or Bone Problems:	Yes or No
Chronic Ear Infections:	Yes or No	Obesity:	Yes or No
Congestive Heart Failure (CHF):	Yes or No	Osteoporosis:	Yes or No
Constipation:	Yes or No	Other:________________________________	
Coronary Artery Dease :	Yes or No	Ovarian Cancer:	Yes or No
Depression:	Yes or No	Polyps:	Yes or No
Developmental or Behavioral Disorders:	Yes or No	Pre-Eclampsia:	Yes or No
Diabetes:	Yes or No	Pulmonary Embolism:	Yes or No
Difficulty Swallowing:	Yes or No	Reflux/GERD:	Yes or No
Diverticulitis:	Yes or No	Seizures/Epilepsy :	Yes or No
Ear or Hearing Problems:	Yes or No	Skin Problems:	Yes or No
Eating Disorder :	Yes or No	Stroke :	Yes or No
Eczema:	Yes or No	Thrombophilias:	Yes or No
Endometriosis:	Yes or No	Thyroid Problems:	Yes or No
Fibromyalgia:	Yes or No	Tuberculosis:	Yes or No
GI Problems:	Yes or No	Varicosities:	Yes or No
Gout:	Yes or No	Vision or Eye Problems:	Yes or No

Past Surgical History:

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____

____

Social History

Name _______________________________ DOB _______________ Today's Date_______

Substance use:

Please circle your answer

Do you or have you ever smoked tobacco?

Never smoked   Former smoker   Current every day Smoker

Do you or have you ever used any other forms of tobacco or nicotine? Yes or No

What was the date of your most recent tobacco screening? _________

Has tobacco cessation counseling been provided? Yes or No

What is your level of alcohol consumption? None Occasional Moderate Heavy
Do you use any illicit or recreational drugs? Yes or No

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? ____

What is your level of caffeine consumption? None Occasional Moderate Heavy

Education and Occupation:

What is the highest grade or level of school you have completed or the highest degree you have received? ______________________________

Are you currently in school? Yes Or No

Are you currently employed? Yes or no

Activities of Daily Living

Name ________________________ DOB ___________ Today's Date____________

Please circle your answer

Are you able to care for yourself? Yes or No

Are you blind or do you have difficulty seeing? Yes or No

Are you deaf or do you have serious difficulty hearing? Yes or No

Do you have difficulty concentrating, remembering, or making decisions? Yes or No

Do you have difficulty walking or climbing stairs? Yes or No

Do you have difficulty dressing or bathing? Yes or No

Do you have difficulty doing errands alone? Yes or No

Are you able to walk? Yes or No

Do you have transportation difficulties? Yes or No

Which of your hands is dominant? ______________________

Marriage and Sexuality:

What is your relationship status? Married Single Divorced Separated Widowed Domestic partner

Are you sexually active? Yes or No

What contraceptive method was reported at start of this visit? _______________________

How many children do you have? __________________________________

Lifestyle:

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?
Not at all Only a little To some Extent Rather much Very much

Do you participate in social media? Yes or No

Do you wear a helmet when biking? Yes or No

Do you use your seat belt or car seat routinely? Yes or No

Notes:____
____
____

Home and Environment

Name ________________________________ DOB ________________ Today's Date________

Please circle your answer

Have there been any changes to your family or social situation? Yes or No

Are you a caregiver? Yes or No

What type of child care do you use? None Relative Private Sitter Daycare/ Preschool

Where do you live? Single- level house Multi-level house Apartment Trailer Condo Nursing home
Other ________________________

How long have you lived there? ______________________________

Do you have any pets? Yes or No

Do you have an electrostatic air filter? Yes or No

Do you have a humidifier? Yes or No

Is your home air conditioned? Yes or No

Do you have moisture problems in your home? Yes or No

Do you have a basement? Yes or No

Do you have smoke and carbon monoxide detectors in your home? Yes or No

Are you passively exposed to smoke? Yes or No

Are there any smokers in your house? Yes or No

Are there any guns present in your home? Yes or No

What is the fluoride status of your home? Fluoridated non-fluoridated unknown
Do you use insect repellent routinely? Yes or No

Do you use sunscreen routinely? Yes or No

What type of noise exposure are you exposed to? Yes or No

Have you been exposed to chemicals or toxins? Yes or No

Have you been exposed to heavy metals? Yes or No

Notes
____
____
____
____

Advance Directive

Name ___________________________________ DOB _________________ Today's Date________

Please circle your answer

Do you have an advance directive? Yes or No

What is your code status? Full code DNR DNI DNR/DNI CMO Other ____________________

Do you have an out of hospital DNR? Yes or No

Do you have a medical power of attorney? Yes or No

Do you have a directive to physicians? Yes or No

Is blood transfusion acceptable in an emergency? Yes or No

Do you have a patient advocate? Yes or No

Family History

(list any past or current medical conditions for the following family members)

Are you adopted? Y N

Mother- Alive Deceased

(if deceased due to medical condition, specify) ________________

Father- Alive Deceased

(if deceased due to medical condition, specify) ________________

Sister (s)- Alive Deceased

(if deceased due to medical condition, specify) ______________________

Brother(s)- Alive Deceased

(if deceased due to medical condition, specify) ______________________

Paternal Grandmother- Alive Deceased

(if deceased due to medical condition, specify) ____________________________

Paternal Grandfather- Alive Deceased

(if deceased due to medical condition, specify) ______________________________

Maternal Grandmother- Alive Deceased

(if deceased due to medical condition, specify) ______________________________

Maternal Grandfather- Alive Deceased

(if deceased due to medical condition, specify) ______________________________

Other Paternal Relatives-

Other Maternal Relatives-

The Family Practice Financial Policy

Print Patient Name____

PLEASE SIGN POLICY BELOW

Thank you for choosing The Family Practice as your health care provider. We are committed to providing you with quality and affordable health care. This financial policy was developed to assist with questions you have or that may arise with regards to financial issues. We believe that stating our expectations with regards to financial issues helps us concentrate on our mission of providing excellent care.

1. Insurance- We participate in most insurance plans. If you are not insured by a plan we have a contract with or you are insured but do not have a copy of a current card, payment is due in full at time of service. We will bill your insurance company once we receive a copy of your current card, but payment will be your responsibility at time of service.

2. Co-payments- All copays and deductibles must be paid at the time of service. Copays that are not paid at the time of service will be billed a $25.00 administrative fee. This fee and your copay will need to be paid prior to future appointments.

3. Deductibles- Because more insurance companies are issuing policies with very high deductibles, we will need to collect deductibles that have not been met at time of service. It is your responsibility to call your insurance company priorto being seen to see if you have met your deductible. We have formulated a fee amount that we have tried to make as close as possible to the allowable amount that will be covered by your insurance company. Anything over paid or under paid will either be credited or billed to you accordingly. If you do not call your insurance company prior to being seen we will assume that you have not met your deductible and payment of the allowable amount is due at time of service.

4. Non-covered services- It is virtually impossible for us to have knowledge of what services each insurance plan covers. Knowing your insurance benefits is your responsibility. Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.

5. No show appointments- For any second no show appointment there will be a $25.00 fee. This amount will need to be paid prior to any future appointments. A no show appointment is defined as any appointment not cancelled 24 hours in advance.

6. Statements/Bills- After 90 days past due, you will receive a pre-collection letter stating you have 10 days to pay your balance. If we do not receive payment, you will then receive a collection letter stating you have 10 days to pay your balance or be turned over to a collection agency. Once an account is turned over to collections, we will no longer see or treat anyone in the family, even after the balance is paid. The Family Practice is not responsible for any disputes regarding your balance due. Any questions or problems need to be addressed directly to your insurance company.

7. Non Sufficient Fund Check- Any check that is returned to us will be assessed a $25.00 return check fee. The amount of the NSF check and the $25.00 fee will need to be paid by cash or with credit card within 10 days or it will be turned over to a collection agency at which time we will no longer be able to see or treat anyone in the family.

8. Assignment of Benefits- I, the undersigned, realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to The Family Practice and Dr. Robert P. Vogt any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments. I have read and understand the financial policy and agree to abide by it.

Signature of patient or responsible party ________________________________ Date____________

The Family Practice

Phone Message Consent Form

Notice of Privacy Practices – Patient Acknowledgement

We, at the Family Practice, are committed to safeguarding the privacy and confidentially of your medical records including the personal information that you share with us. We comply with the Health Insurance Portability and accountability Act of 1996 (HIPAA).

From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

Patient Name: ____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CIRCLE ALL THAT APPLY)

HOME PHONE: ____

LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO

LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

CELL PHONE: ____

LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO

LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

OTHER REQUESTS: ____

May we speak to someone else regarding your medical care? YES NO

Name of Person: Relationship:

__________________________________ ______________________

__________________________________ ______________________

I understand that I may revoke this consent at any time.

Signature: ____

Witness: _______________________ Date: _____________________

Acknowledgement of Receipt of Notice

Dr. Robert Vogt, The Family Practice, 6005 Delmonico Dr., Ste. 150 Dr.

Robert Vogt, 719-266-5244

I hereby acknowledge that a copy of this medical practice's Notice of Privacy Practices with effective date of September 30, 2013 was posted and available to read in the reception area and I also acknowledge that it is available for me to read on this practice’s website www.thefamilypractice.org

Signed: ______________________________ Date: __________________________

Print Name: __________________________ Telephone: _____________________

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: ____

____

For Office Use Only:

- ❑ Signed form received by: ______________________________
- ❑ Acknowledgment refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

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