

**PATIENT INFORMATION
FILL OUT ALL ITEMS**

FAILURE TO COMPLETELY FILL OUT THIS FORM MAY RESULT IN YOU BEING BILLED IN FULL

Patient Last Name:	First:	MI:
Address:		
City:	State:	Zip:
Date of Birth:	Gender: M or F	Marital Status: M S D W
Home Phone:	Cell Phone:	Preferred contact phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		<input type="checkbox"/> Rather Not Say
Race: <input type="checkbox"/> White Non-Hispanic <input type="checkbox"/> White Hispanic/Latino <input type="checkbox"/> Black/African American <input type="checkbox"/> Other:		<input type="checkbox"/> Rather Not Say
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		<input type="checkbox"/> Rather Not Say
Spouse's Name:	Email Address:	
Employer Name:	Work Phone:	
Work City:	Work State:	Work Zip:
Preferred Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Cross Streets:	Pharmacy City:	
Name of nearest relative not living with you:	Phone:	
Who do we contact in case of an emergency?	Phone:	
Where did you hear about us:		

INSURANCE POLICY HOLDER INFORMATION

**WE NEED A COPY OF YOUR INSURANCE CARD(s) AND
PLEASE MAKE SURE DR. BENJAMIN SCHNURR, DO IS THE PCP LISTED ON YOUR PLAN PRIOR TO CONSULTING
OR YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURED**

<u>PRIMARY INSURANCE INFORMATION:</u>		
Policy Holder's Last Name:	First:	DOB:
Insurance Carrier Name:	ID#:	Group#:
Claims Address (on back of card):		

<u>SECONDARY INSURANCE INFORMATION (IF APPLICABLE):</u>		
Policy Holder's Last Name:	First:	DOB:
Insurance Carrier Name:	ID#:	Group#:
Claims Address (on back of card):		

By signing below I certify the above information is correct to the best of my knowledge. I hereby authorize the South Denver Primary Care, PC dba Aspire Family Medicine (PRACTICE) and its providers (PROVIDERS) to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the PROVIDERS any medical benefits otherwise payable to me for his/her services as prescribed, realizing that I am responsible to pay for any non-covered services. I understand that a \$25 billing charge will be added at 60 days to any outstanding balance remaining after insurance has paid, and any charges necessary for the collection of my debt. A 30% collection agency fee will be added if account goes to collection.

By signing below I certify I have been given an opportunity to review the practice's most recent "Notice Of Privacy Practices" and the "PATIENT FINANCIAL POLICY" documents and I agree to all of the terms and conditions contained in these documents for this and any future visits. I understand that if I fail to cancel any scheduled appointment within 24 hours of my appointment time my account will be billed a \$75.00 No-Show fee that is not covered by medical insurance.

Signature of Patient or Guardian (if Minor): _____	Date: _____
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SOUTH DENVER PRIMARY CARE, PC
DBA Aspire Family Medicine
(collectively referred to here after as "MEDICAL PRACTICE")

Patient Name: _____ **Birth Date:** _____

HIPAA PRIVACY CONSENT

By signing below the above named patient or the guardian of the patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- Medical Practice has a "Notice of Privacy Practices" document and the patient/guardian has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices at any time
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Medical Practice may condition treatment upon the execution of this Consent
- Medical Practice endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

MEDICAL INFORMATION RELEASE

By signing below, I authorize MEDICAL PRACTICE to release ALL medical information for the above named patient to the individuals listed below. This information could include blood test results, x-ray results, consultation reports, sexually transmitted disease testing results, HIV testing results, information on mental disease and substance abuse, etc.

Person(s) who may receive my medication information:

NONE

Information I DO NOT wish to share with the above named individual(s) includes:

CONSENT TO TREAT:

I hereby consent to evaluation, testing and treatment for me or my dependents as directed by my physician or his or her designee at MEDICAL PRACTICE.

By signing below, I certify I have read and understand and agree to the content above including the HIPAA PRIVACY CONSENT, MEDICAL INFORMATION RELEASE, AND CONSENT TO TREATMENT.

Signed: _____ Date: _____

This consent was signed by (please print): _____

Relationship of the person who signed to the patient: Self Parent Guardian Other: _____

PLEASE FILL OUT BOTH SIDES OF THIS FORM
SOUTH DENVER PRIMARY CARE, PC
DBA Aspire Family Medicine
(collectively referred to here after as "MEDICAL PRACTICE")

Patient Name: _____ **Birth Date:** _____

AUTHORIZATION TO LEAVE TELEPHONE MESSAGES

- Yes**
I Authorize
- No**
I Do Not
Authorize

There are times when it may be more convenient for our staff to leave you a detailed telephone message regarding testing results or other matters. These situations include normal testing results (normal blood work, negative strep test, normal xrays, etc) or slightly abnormal results that require no immediate follow-up. **Sensitive test results (i.e. positive HIV testing, etc) or testing results that require a new treatment plan ARE NOT left on answering machines or voice mails. In these situations we will leave a message for you to call our office or mail you a letter requesting follow up in our office.**

By checking the accept area to the left, I authorize South Denver Primary Care, PC dba Aspire Family Medicine to leave a message on my home or cell phone answering machine or voice mail regarding testing results and other matters. I understand telephones, cells phones, voice mail and answering machines may not be a secure form of communication. If you wish to decline, please check the appropriate area to the left.

- Yes**
I Authorize
- No**
I Do Not
Authorize

AUTHORIZATION TO SEND A TEXT MESSAGES

I authorize MEDICAL PRACTICE to send text messages that would include appointment reminders and other matters to me on my provided cell phone number. I understand that text message charges from my cell phone provider may apply. I understand that text messages are not considered a secure or encrypted form of communication and are NOT HIPAA compliant. Please check appropriate box to the left.

- Yes**
I Authorize
- No**
I Do Not
Authorize

AUTHORIZATION TO SEND EMAIL MESSAGES

Periodically our practice sends out emails to our patients providing them updates on current medical issues we feel may be relevant to them (i.e. influenza vaccine clinics in our office, etc). We generally sent out these types of emails four times a year. We may also utilize email to send appointment reminders to our patients. **WE DO NOT SELL OR GIVE AWAY YOUR EMAIL!**

I authorize MEDICAL PRACTICE to send periodic emails and appointment reminder emails to me at the email address I have provided. I understand email is not a secure form of communication and is not HIPAA compliant. Please check appropriate box to the left.

By signing below, I certify I have read and understand and agree to the content. I have also initialed my choice regarding the AUTHORIZATION TO LEAVE TELEPHONE MESSAGES REGARDING TEST RESULTS, AUTHORIZATION TO SEND A TEXT MESSAGE APPOINTMENT REMINDER, AND AUTHORIZATION TO SEND EMAIL MESSAGES.

Signed: _____ **Date:** _____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

MEDICAL HISTORY FORM

Name _____ Age _____

Male Female Date of birth ____/____/____

Married Divorced Widowed

Occupation _____ Since _____

Last Grade Finished _____

Hobbies/Interests _____

Last Physical Exam was _____ years ago

Where if not this office _____

REASON FOR YOUR VISIT TODAY:

FAMILY MEDICAL HISTORY

(PLEASE CHECK ALL THAT APPLY)

	Father	Mother	Grand Parents	Siblings	Children
High Cholesterol	___	___	___	___	___
High Blood Pressure	___	___	___	___	___
Heart Attack	___	___	___	___	___
Heart Disease	___	___	___	___	___
Stroke	___	___	___	___	___
Glaucoma	___	___	___	___	___
Diabetes	___	___	___	___	___
Epilepsy/Seizures	___	___	___	___	___
Bleeding Disorder	___	___	___	___	___
Kidney Disease	___	___	___	___	___
Asthma/Emphysema	___	___	___	___	___
Thyroid Disease	___	___	___	___	___
Ulcer/Bowel Prob	___	___	___	___	___
Lung Problem	___	___	___	___	___
Suicide Attempt	___	___	___	___	___
Mental Illness	___	___	___	___	___
Alcoholism	___	___	___	___	___
Substance abuse	___	___	___	___	___
Cancer	___	___	___	___	___

If cancer, what type: _____

Other medical issues(specify) _____

Medicine Allergies: List any allergies and reaction:

Medicine:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL MEDICAL HISTORY (PLEASE CHECK ALL ITEMS)

Please indicate if you have had any of the following

- | | |
|--|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes –High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes – Frequent Urine Infection |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –High Cholesterol | <input type="checkbox"/> No <input type="checkbox"/> Yes –Pneumonia / Pleurisy |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes –Asthma/ COPD |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Heart Attack / Stroke | <input type="checkbox"/> No <input type="checkbox"/> Yes –Arthritis / Rheumatism |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Cancer
Type: _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes –Gout |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Hay Fever/Allergies | <input type="checkbox"/> No <input type="checkbox"/> Yes –Bone Fracture / Joint Injury |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Diverticulosis | <input type="checkbox"/> No <input type="checkbox"/> Yes –Psoriasis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Gall Bladder Trouble | <input type="checkbox"/> No <input type="checkbox"/> Yes –Anemia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Peptic Ulcers | <input type="checkbox"/> No <input type="checkbox"/> Yes –Insomnia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Heart Burn / Reflux | <input type="checkbox"/> No <input type="checkbox"/> Yes –Depression |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes –Anxiety |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Hernia | <input type="checkbox"/> No <input type="checkbox"/> Yes –Bipolar Disorder |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Hemorrhoids | <input type="checkbox"/> No <input type="checkbox"/> Yes –Alcohol Abuse |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Low/High Thyroid Level | <input type="checkbox"/> No <input type="checkbox"/> Yes –Substance Abuse |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes –Suicidal Thoughts |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Migraine | <input type="checkbox"/> No <input type="checkbox"/> Yes –Suicide Attempt |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Bleeding disorder | Other: _____ |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Blood clots | _____ |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Kidney failure | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes –Kidney stone | |

HOSPITALIZATIONS/SURGERIES

List illnesses requiring hospitalizations, operations & year.

IMMUNIZATIONS: (year most recently received)

Pneumonia _____ Tetanus _____

Flu _____ Hepatitis A _____

Shingles _____ Other _____

TESTS: Indicate year(s) completed

Colonoscopy _____ Upper endoscopy _____

Mammogram _____ Pap Smear _____

Other _____

Any colon polyps in the past: No Yes

Any abnormal mammograms: No Yes (Women Only)

Any abnormal pap smears: No Yes (Women Only)

List all medicines you are taking. Include medicines, oral contraceptives, vitamins, etc., which you take with or without a prescription. Indicate if you use them only occasionally.

Name of Medication	Dose	How often do you take it	Name of Medication	Dose	How often do you take it
1.) _____	_____	_____	2.) _____	_____	_____
3.) _____	_____	_____	4.) _____	_____	_____
5.) _____	_____	_____	6.) _____	_____	_____
7.) _____	_____	_____	8.) _____	_____	_____

Have you had any of the follow symptoms in the last 6 months – Please answer all items

- No Yes - Chronic Fatigue
- No Yes – Unusual Weight Change
- No Yes – Fever or Chills
- No Yes – Sore Throat-Frequent
- No Yes – Change in hearing/Ringing in the Ears
- No Yes – Nasal Congestion / Runny nose
- No Yes –Nose Bleeds- Frequent
- No Yes –Shortness of Breath
- No Yes –Wheezing
- No Yes –Chronic Cough
- No Yes –Chest Pain
- No Yes –Palpitations / Racing Heart
- No Yes –Leg Swelling
- No Yes –Leg Pain When Walking
- No Yes –Irregular Pulse
- No Yes –Abdominal Pain
- No Yes –Loss of Appetite
- No Yes –Indigestion / Heartburn
- No Yes –Persistent Nausea / Vomiting
- No Yes –Constipation
- No Yes –Diarrhea
- No Yes –Bloody stool / Black Tarry Stools
- No Yes –Changes in Bowel Habits
- No Yes –Blood in Urine
- No Yes –Burning with Urination
- No Yes –Frequent overnight urination
- No Yes –Urinary Difficulty in Starting/Stopping
- No Yes –Decrease in Force of Urination
- No Yes –Back Pain
- No Yes –Joint Pain
- No Yes –Joint Swelling
- No Yes –Hives
- No Yes –Rashes
- No Yes –Changing moles
- No Yes –Headache
- No Yes –Tremor/Hands Shake
- No Yes –Numbness or Weakness or Tingling
- No Yes –Difficulty Sleeping
- No Yes –Nervousness / Anxious
- No Yes –Depressed
- No Yes –Memory Loss
- No Yes –Moodiness – excessive intolerance
- No Yes –Lymph nodes swollen
- No Yes –Other (Specify) _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

WOMEN ONLY: Please answer all items below

- What age did you begin menstruation? _____
- What date did your last menstrual period begin? _____
- How many days of flow do you generally have? _____
- No Yes –Any abnormal pain/cramps, bleeding/spotting, excessive flow?
 - No Yes –Any vaginal unusual discharge?
 - No Yes –Any pain or bleeding after sex?
 - No Yes –Have you ever had any sexual difficulties?
 - No Yes –Do you do a self breast exam? How often? _____
 - No Yes –Have you noticed any breast lumps/pain/discharge?
 - No Yes –How many times have you been pregnant? _____
 - No Yes –Have you ever breastfed any of your children?
 - No Yes –Have any close relatives had breast cancer/disease?
 - No Yes –Have you had an abortion or miscarriage?
 - No Yes –Are you currently using contraception?
What kind? _____

MEN ONLY: Please answer all items below

- No Yes –Have you ever had any prostate trouble?
- No Yes –Have you ever had any sexual difficulties?
- No Yes –Have you had a vasectomy?

LIFE STYLE – ALL PATIENTS:

Please answer all items below

- No Yes –Have you ever smoked cigarettes?
If yes: How many cigs per day?_____
How many years:_____
No Yes –Are you still smoking?
- No Yes –Are you using other tobacco products (Cigars,Chew, Snus)
- No Yes –Do you consume alcohol?
If yes, how many 12oz beers, 5 oz of wine and/or 1.5oz of liquor do you consume per week?_____
- No Yes –Do you use or take marijuana in any form?
If yes: How frequently do you use marijuana?_____
No Yes –Do you have a marijuana card?
Reason for card?_____
- No Yes –Do you use other illicit or illegal drugs?
If yes: Please describe?_____
- No Yes –Do you drink coffee/tea/cola-soft drinks?
If yes: How many per day?_____
- No Yes –Do you exercise regularly at least 30 minutes 4 or more times per week?
- No Yes –Do you see a dentist every 6 months?
Last visit date:_____

Anything else you want to mention:

By signing below I certify that the answers contained in this questionnaire are correct to the best of my knowledge. I understand that if false or incorrect medical information is provided that this can have potentially serious effects on my health and can potentially delay the diagnosis of serious medical conditions.

Patient Signature :

Date: _____/_____/_____

IMPORTANT INFORMATION REGARDING INSURANCE COVERAGE OF YOUR PHYSICAL EXAM TODAY

WHAT IS TYPICALLY COVERED DURING YOUR PHYSICAL?

MOST MEDICAL INSURANCE COMPANIES COVER THE FOLLOWING AS PART OF YOUR PHYSICAL EXAM VISIT:

- Weight, height, blood pressure and body mass index calculation
- Medical history review
- Physical exam by our provider (including a pap smear for females)
- Screening for high blood pressure, cholesterol, diabetes if indicated
- Screening for certain forms of cancer such as cervical or prostate cancer
- The following may be covered but are not done in this office
 - Mammogram, bone density, colonoscopy

WHAT IS NOT COVERED?

YOUR MEDICAL INSURANCE COMPANY **MAY NOT** COVER THE FOLLOWING DURING A PHYSICAL EXAM:

- **Evaluation** of a specific SYMPTOMS, MEDICAL PROBLEMS OR ILLNESSES such as cough, sore throat, rash, injury, abdominal pain, depression/anxiety, stress, high blood pressure, diabetes, high cholesterol or any medical issue that requires additional evaluation by your provider.
- **Medication Refills** of a specific medical condition
- **Procedures** such as mole removal, skin biopsies, or joint injections

WHAT IF I HAVE A MEDICAL ISSUE I NEED TO DISCUSS TODAY?

Our providers will welcome discussing and providing any service but **YOU ARE RESPONSIBLE FOR PAYMENT ON ANY SERVICE THAT IS NOT PART OF YOUR PHYSICAL INCLUDING ANY CO-PAYMENT, COINSURANCE OR DEDUCTIBLE. WE COLLECT THESE PAYMENTS AT THE TIME OF SERVICE.**

YOU ALSO HAVE THE OPTION OF BEING SEEN TODAY FOR YOUR MEDICAL ISSUE(S) AND WE WILL BE HAPPY TO RESCHEDULE YOUR PHYSICAL EXAM FOR A LATER DATE.

Note that it is your responsibility to know your insurance plans benefits and exclusions. Our office does not verify coverage, benefits or your out of pocket cost for services provided prior to you being seen

By signing below, I acknowledge that I have read and understand the above statements.

Signature

Date

Print Your Name On This Line Please