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 ______
Home Phone: ______ Cell Phone: ______ Preferred contact phone: ☐Cell ☐Home
Language Preference: ☐English ☐Spanish ☐Other ______ ☐Rather Not Say
Race: ☐White Non-Hispanic ☐White Hispanic/Latino ☐Black/African American ☐Other: ______ ☐Rather Not Say
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic/Non-Latino ☐Rather Not Say
Parent(s) Name(s): ______ Email Address: ______.
Parent Employer Name: ______ Work Phone: ______
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

PRIMARY INSURANCE INFORMATION:
Policy Holder's Last Name: ______ **First:** ______ **DOB:** ______.
Insurance Carrier Name: ______ **ID#:** ______ Group#: ______.
Claims Address (on back of card): ______.

SECONDARY INSURANCE INFORMATION (IF APPLICABLE):
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:**______________

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:____________

☐Yes
I Authorize

☐No
I Do Not Authorize

AUTHORIZATION TO LEAVE TELEPHONE MESSAGES

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

Pediatric Medical History

Today's Date		To help us meet your healthcare needs, please fill out all items. This is confidential record of your child's medical history and will be kept in this office.

PATIENT INFORMATION

Patient Name (First) (Middle) (Last)	Date of Birth	Gender: ☐ Male ☐ Female

Person filling out this form: ☐ Father ☐ Mother ☐ Other ____________________	Father Name	Father Age	Mother Name	Mother Age

Chief Complaints: (Please list in order of importance the present health concerns, symptoms or problems the child is experiencing)

Please list any current medications, herbal supplements or vitamins your child is taking. Please include dosages and how you were directed to take them. ☐ None

List any allergies: (foods, drugs, environment) **and reaction patient had** when they were exposed: ☐ None

PREGNANCY AND BIRTH

Born at how many weeks:	Birth Weigh:	☐ Vaginal ☐ Cesarean If Cesarean, Reason: ______________________________	

Did the mother have any illness during the pregnancy (gestational diabetes, pre-eclampsia, on and medications, etc)? ☐ No ☐ Yes If yes, provide details below

____

Any complications during or after birth with the patient (rapid breathing, jaundice, infection, extended stay at the hospital, etc)? ☐ No ☐ Yes If yes, provide details

____

PAST MEDICAL HISTORY

Please list all serious illnesses, medical problems, accidents and injuries, and hospitalizations (other than surgeries) with dates: ☐ None

Describe all operations, surgeries, or medical procedures (include dates): ☐ None

Are the patient's vaccinations up to date? ☐ Yes ☐ No ☐ Don't know ____	Has your child had reaction to any immunizations? ☐ No ☐ Yes, Explain: ________________________________

Last Well Child Exam: When? _________ Last Dental Exam: When? _________ Last Eye Exam: When? __________ Last Hearing Exam: When?_________

FAMILY / SOCIAL HISTORY

Please fill in information regarding patient's biological family below:

Father Health Issues: ___________________________________ ☐ None

Mother Health Issues: ___________________________________ ☐ None

Sibling 1 Name:_________________ Age_____ Gender: ☐ Male ☐ Female

Sibling 2 Name:_________________ Age_____ Gender: ☐ Male ☐ Female

Sibling 3 Name:_________________ Age_____ Gender: ☐ Male ☐ Female

Sibling 4 Name:_________________ Age_____ Gender: ☐ Male ☐ Female

Please list additional siblings below or on the back of this form.

Do any of the patient's siblings have any health issues? If so please describe:

____

____

____

____

Do any siblings, parents, or grandparents have any of the following conditions or medical problems?

	Yes	No		Yes	No
Heart Disease	☐	☐	Bleeding Disorder	☐	☐
High Cholesterol	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Asthma	☐	☐
Obesity	☐	☐	Eczema/Dry Skin	☐	☐
Diabetes	☐	☐	Depression	☐	☐
High Blood Pressure	☐	☐	Alcohol/Drug Problem	☐	☐
Tuberculosis Contact	☐	☐	Other Mental Illness	☐	☐
Cancer	☐	☐			

If you answered Yes to any of the above, please explain:

____

____

____

FEEDING AND NUTRITION

For Infants: ☐ Breastfed ☐ Bottle fed Formula Brand __________________

How frequently does your infant feed (i.e. every 4 hours)? _______________

If breastfed, how long does your infant breastfeed? _____________________

If formula fed, how many ounces does your infant take per feed? ___________

For Toddlers and Adolescents:

Describe the patient's diet?____

____

____

Pediatric Medical History

Today's Date	

To help us meet your healthcare needs, please fill out all items.
This is confidential record of your child's medical history and will be kept in this office.

PATIENT INFORMATION

Patient Name (First) (Middle) (Last)	Date of Birth

REVIEW OF SYSTEMS / DISEASES / DEVELOPMENT HISTORY

Please indicate if the patient has had any of the following:

	Yes	No		Yes	No
General					
Fever/Chills			Night sweats		
Unusual weight change					
HEENT					
Nose bleeds			Recurrent ear infections		
Hearing loss			Vision problems		
Snoring			Teeth/Gum problems		
Cardiovascular					
Heart murmur			Congenital heart problems		
Passing out/blacking out			Dizziness		
Respiratory					
Asthma/Wheezing			RSV/Bronchiolitis		
Cough			Shortness of breath		
Pneumonia					
Gastrointestinal					
Nausea/Vomiting			Constipation/Diarrhea		
Bloody stools			Reflux/Spitting up		
Abdominal pain					

	Yes	No		Yes	No
Genitourinary					
Bedwetting			UTI		
Musculoskeletal					
Joint pain/swelling			Fractured bones		
Lymphatic					
Unexplained lumps			Easy bruising/bleeding		
Neurologic					
Seizures			Headaches		
Developmental problems			Weakness		
Speech delay			Hyperactivity		
Skin					
Rashes			Unusual moles/lesions		
Allergy					
Chronic congestion			Itchy eyes		
Psychiatric					
Depression			Anxiety		
Sleep problems			Excessive stress		
Discipline issues					

Does the patient have any other symptoms not listed above? No Yes If yes, please explain: ____

____

SOCIAL / SAFETY / ENVIRONMENTAL HISTORY

Current grade in school:_____ Name of school:_____________________________________

Are there any concerns at school No Yes If yes, please explain ____

Does the patient live in house apartment mobile home other __________________

Patients biological parents are Married Divorced Separated Widowed Other________________________

Does the patient always use a car seat/seat belt when riding in a car? No Yes

Are there any smokers who live in the house? No Yes

Does your child always wear a helmet when riding a bicycle, scooter, skateboard, rollerblading or skating? No Yes

Are there any guns in the house? No Yes
If yes, are they locked? No Yes

Are there any recent stressors in the family or at home right now (i.e. death in the family, unemployment)? No Yes
If yes, please explain:____

Is there any physical or verbal abuse taking place in the home? No Yes

Adolescent Age BOYS ONLY

Please check all that apply: Does the patient use: Tobacco Alcohol Drugs Caffeine (amount)___________________

Does the patient have any of the following: Lump in testicles Painful urination

Adolescent Age GIRLS ONLY

Please check all that apply: Does the patient use: Tobacco Alcohol Drugs Caffeine (amount)___________________

Age of patient when she had her first period: ________ Average length of period (days):________ Days between periods: _________

Pain/heavy flow with periods No Yes Bleed/spot between periods? No Yes Vaginal itching or discharge? No Yes

First day of last period: ________________ Date of last pelvic/female exam: ____________________

Sexually active? No Yes Using birth control? No Yes Type of birth control: _____________ Ever been pregnant? No Yes

ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any change in my child's medical status.

Signature of patient, parent or legal guardian:	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