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: ☐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

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

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:**_____

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.** Some of the content of these voicemail messages may contained PHI (protected health information) covered under HIPAA privacy/security act.

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.

AUTHORIZATION TO SEND A TEXT MESSAGES

☐Yes
I Authorize

☐No
I Do Not Authorize

I authorize MEDICAL PRACTICE to send text messages that would include appointment reminders, billing reminders, overdue invoices/account balances, medical follow up notifications, urgent notifications (i.e. your provider needs to notify you right away about a test result or other health issue) and other matters to me on my provided cell phone number. Some of this content may contained PHI (protected health information) covered under HIPAA privacy/security act. 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.

AUTHORIZATION TO SEND EMAIL MESSAGES

☐Yes
I Authorize

☐No
I Do Not Authorize

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, billing reminders, billing invoices and other matters to our patients. Some of this content may contain PHI (protected health information) covered under HIPAA privacy/security act. **WE DO NOT SELL OR GIVE AWAY YOUR EMAIL!**

I authorize MEDICAL PRACTICE to send periodic 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.

Your privacy is important to us! The above authorizations allow us to communicate with you more conveniently with your permission. The above authorizations may be revoked at any time.

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, AUTHORIZATION TO SEND A TEXT MESSAGES, 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

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

_____

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
☐No ☐Yes –Heat OR Cold 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: _____/_____/_____