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:**_____

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

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 _____

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

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

Patients biological parents are ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other_____

Are there any smokers who live in the house? ☐ 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