Patient Medical History

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Referred By: Friend/Family: _____ Healthcare Provider: _____ Website: _____

Facility: _____ Insurance Company: _____ Advertisement: _____ Other:_____

Issue(s) you wish to discuss today: _____

Allergies: _____

List medications and dose you are on:(□See Attached List)

Have you had any of the following health problems? Check all that apply. □None apply

□ Heart attack	□ Asthma	□ Back problems	□ Bleeding/clotting	□ Arthritis
□ Heart disease	□ Emphysema	□ Diabetes	□ Anemia	□ Migraines
□ Chest pain	□ Stroke	□ Mental Illness	□ AIDS/HIV	□ Cancer. Type:_____
□ High blood pressure	□ Seizures	□ Thyroid problems	□ Reflux disease	□ Other: _____

Please list any surgeries you have had including dates: _____

Has anyone in your family had the following health problems? Check all that apply and list relationship. □None apply

□ High blood pressure_____	□ Diabetes_____	□ Bleeding Disorder_____
□ Heart disease_____	□ Asthma_____	□ Cancer, Type_____
□ Thyroid problems_____	□ Arthritis/Joint pain_____	□ Other:_____
□ Stroke_____	□ Mental Illness_____	□ _____

Have you ever smoked? No Yes **Do you smoke now?** No Yes - if yes, _____packs per day for the last _____years

Alcohol use? ____drinks per □day □week □month **Recreational drug use? (**circle) Yes No Type(s): _____

What is your occupation? _____ **Exercise Routine:**_____

Relationship Status: married single divorced widow(er) **Sexual Identity:**_____

Have you had any of the following in the last month: (Mark with an X)

General
- □ No problems
- □ Fever
- □ Weight loss
- □ Weight gain
- □ Night sweats

Ears
- □ No problems
- □ Hearing loss
- □ Ear pain

Nose
- □ No problems
- □ Congestion/Obstruction
- □ Post nasal drip

Throat
- □ No problems
- □ Sore throat
- □ Chronic cough
- □ Difficulty swallowing

Pulmonary
- □ No problems
- □ Wheezing
- □ Coughing
- □ Shortness of breath

Gastrointestinal
- □ No problems
- □ Nausea/vomiting
- □ Heartburn
- □ Abdominal pain
- □ Constipation/Diarrhea
- □ Blood in stool

Musculoskeletal
- □ No problems
- □ Joint/Back pain
- □ Muscle weakness
- □ Balance issues

Genitourinary
- □ No problems
- □ Painful urination
- □ Frequent urination
- □ Blood in urine
- □ Incontinence

Cardiovascular
- □ No problems
- □ Chest pain
- □ Swollen ankles
- □ Palpitations
- □

Neurological
- □ No problems
- □ Numbness/weakness
- □ Tingling
- □ Dizziness
- □ Memory loss

Psych
- □ No problems
- □ Depression/anxiety
- □ Insomnia

Hematology/Endo
- □ No problems
- □ Anemia
- □ Bleeding tendency
- □ Heat/cold intolerance

Skin
- □ No problems
- □ Skin lesions
- □ Pigmentation changes

Eyes
- □ No problems
- □ Change in vision

Women
- □ Changing periods
- □ Other concerns

Men
- □ Erectile dysfunction

Please list any other medical providers you see: _____

Do you have an Advanced Directive Yes No

Advanced Care Planning Consent: I consent to discuss end-of-life planning issues with my healthcare provider (circle) Yes No

Please provide month and year you most recently had the following:

Mammogram:_____ Colonoscopy:_____ Bone Density:_____ Pap Smear:_____

Eye Exam:_____ Dental Exam:_____ Dermatology Exam:_____ Tetanus Booster (tdap) :_____

New Patient Registration

Name:_____DOB:_____ Date:_____
Address:_____Apt:_____
City: _____ State:_____ Zip Code:_____ Sex: Female Male
Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone( )_____
E-mail address:_____SSN#:_____-_____-_____ (required for patient portal)
Marital Status: Married Single Divorced Widowed Partner Other: _____
Employment Status: Employed Self-Employed Not Employed Retired Student (Full time/Part time)
Employer Name: _____ Occupation:_____
Employer Address: _____ City:_____ State:_____ Zip Code:_____
Pharmacy Name: _____ Pharmacy Phone: _____
Pharmacy Address: _____
Emergency contact _____ Relationship:_____
Home Phone: _____ Cell: _____ Work: _____

Primary Insurance and Responsible Party Information

Same as above ☐
Responsible Party Name _____
Address:_____Apt:_____
City: _____ State:_____ Zip Code:_____
Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone( )_____
SSN#:_____-_____-_____ Date of Birth:_____ Sex(circle): F M
Employer Name:_____ Occupation:_____
Employer Address:_____ City:_____ State:_____ Zip Code:_____
Insurance Name:_____ Customer service Phone: ( )_____
Subscriber ID:_____ Group ID:_____ Copay $:_____
Effective Date:_____ Termination Date:_____
Billing Address_____
City: _____State: _____Zip Code: _____

Secondary Insurance Information

Insurance Name:_____ Customer service Phone: ( )_____
Subscriber ID:_____ Group ID:_____ Copay $:_____
Effective Date:_____ Termination Date:_____
Billing Address_____
City:_____State:_____Zip Code:_____

Race (please check one)

American Indian or Alaska Native ☐
Asian ☐
Native Hawaiian or Other Pacific Islander ☐
Black or African American ☐
White ☐
Refused to report ☐

Ethnicity (please check one)

Hispanic or Latino origin ☐
Not Hispanic or Latino origin ☐
Refused to report ☐

Language (please check one)

English ☐
Spanish ☐
Other:_____ ☐

Patient (or Responsible Party) Signature: _____Date: _____

Health ONE Aspen Medical Group Physician Care℠

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____(Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, **Aspen Medical Group** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____(Patient or Guardian Initials)

Third Party Collection. I acknowledge that **Aspen Medical Group** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____(Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to **Aspen Medical Group** any insurance or other third-party benefits available for health care services provided to me. I understand **Aspen Medical Group** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Aspen Medical Group,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____(Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Aspen Medical Group** by the Medicare or Medicaid program.

5. _____(Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Aspen Medical Group**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Aspen Medical Group** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Aspen Medical Group** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.
(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____

Late Arrival Policy

We realize emergencies and illnesses occur, however, a courtesy phone call allows us to use our time for another patient. Your cooperation will help us continue to provide quality services and maintain accurate scheduling.

I,_____, understand that I must arrive to my scheduled appointment NO MORE THAN 10 minutes after the appointment time.

If I arrive more than 10 minutes after my appointment time, I may be asked to re-schedule the appointment for another date and/or time.

_____
Patient Printed Name

_____
Patient or Guardian Signature

_____
Today's Date

HOW CAN WE REACH YOU?

From time to time your provider will need to contact you. By filling out the information below we are better able to serve you.

I,_____ by filling in the spaces below give HealthONE my permission to speak with and/or leave a phone message regarding my medical care and/or billing information with the following individuals.

PLEASE CONSIDER CAREFULLY WHOM YOU AUTHORIZE TO HAVE ACCESS TO PROTECTED INFORMATION REGARDING YOUR CARE. I fully understand that this consent will remain valid until revoked in writing.

My Home answering machine#_____ Initials_____
My Cell or Cell voice mail: #_____ Initials_____

My Office/Work voice mail: #_____ Initials_____

My Spouse/Guardian Name: _____
#_____ Initials_____

If other, please name: _____
Relationship to patient: _____
#_____ Initials_____

In an effort to protect your privacy, we have developed a policy on leaving medical care message information.

- We will NOT leave messages with anyone except the patient or legal guardian unless stated above.
- We will NOT leave any confidential information on an answering machine unless stated above.
- We will NOT leave any messages on a voice mail unless stated above.

Signature _____Date_____

Aspen Medical Group

4500 E. 9th Ave. Suite 450
Denver, CO 80220
(p) 303.394.9355
(f) 303.394.1932

Authorization/Release For Use And Disclosure For Protected Health Information (PHI)

Patient Name: _____ **DOB:**_____

Address:_____ **Phone:**_____

City:_____ **State:**_____ **Zip:** _____

For Disclosure Only: I hereby authorize the disclosure of the following Protected Health Information (PHI) of the patient listed above for the purpose of primary follow-up care.

To □ **From □**

Aspen Medical Group
4500 E.9th Ave. Suite 450
Denver, CO 80220
Phone: 303-394.9355 Fax: 303-394.1932

To □ / From □ _____

_____

PH:_____ **Fax:**_____

For Treatment Dates:_____

How would you like to receive your records? _____Will Pick up _____Mail to address above _____ Fax (Please list number above)

Are you transferring care to another provider? □ Yes □ No

Type of Access Required: Copies of the Record □ Inspection of the Record □

Selected Portions of Protected Health Information (PHI):

□ Entire Record □ Lab □ Progress Notes □ Emergency Room □ Imaging/Radiology □ Physicians Orders

□ History/Physical □ Cardiac Studies □ Billing Records □ Consult Report □ Demographics

□ Internal Marketing □ Operative Reports □ Nursing Notes □ Verbal Communications

□ Rehabilitation/ PT □ Medication Logs □ Other: _____

Expiration: This Authorization Will Expire: □ Fulfillment of this Request OR □ Date: _____

1. **I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing/results, or AIDS information._____ (Initial)**
2. **I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).**
3. **I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.**
4. **If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and be re-disclosed.**
5. **I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.**
6. **I will receive a copy of this form after I sign it.**

I have read the above and authorize the disclosure of the Protected Health Information (PHI) as stated.

Signature of Patient/Guardian:_____

Relation to Patient:_____**Date:**_____

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