

Patient Information

Patient Name: _____ Today's Date: _____
Last First MI

Address: _____
Street City State Zip Code

Sex: Male Female Marital Status: Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Home Phone: _____ Work: _____ Cell: _____

Occupation: _____ Email: _____

Referral Information

Whom may we thank for referring you to our practice?

- Another patient, friend
- Another patient, relative
- Dental Office
- Yellow Pages
- Newspaper
- School
- Work
- Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

Name: _____ Relationship: _____

Address: _____

Social Security #: _____ Birth Date: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Insurance Information

Primary Insurance: _____

Address: _____
Street City State Zip Code

Plan ID #: _____ Group #: _____

Policy Holder: _____ Is insured a patient? Yes No
Last First MI

Address: _____
Street City State Zip Code

Insured's Birth Date: _____ Insured's Social Security #: _____

Insured's Employer: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Secondary Insurance: _____

Address: _____
Street City State Zip Code

Plan ID #: _____ Group #: _____

Policy Holder: _____ Is insured a patient? Yes No
Last First MI

Address: _____
Street City State Zip Code

Insured's Birth Date: _____ Insured's Social Security #: _____

Insured's Employer: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____



Andover Family Medicine
105 S. Andover Rd. Suite D
Andover, KS 67002

Assignment of Benefits:

This assignment of benefits allows Andover Family Medicine to be paid directly by my health insurance carrier, Medicare, Medigap or other health benefit plan for the services Andover Family Medicine provides to me, my minor child or other person entitled to health care benefits for services provided. In return for the services rendered by Andover Family Medicine, I hereby irrevocably assign and transfer to Andover Family Medicine all right, title, and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting Andover Family Medicine an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of Andover Family Medicine to pursue any such right of recovery. In no event will Andover Family Medicine retain benefits in excess of the amount owed to Andover Family Medicine for the care and treatment rendered. I understand that it is my responsibility to satisfy any conditions of my insurance company. I have read and been given the opportunity to ask questions about this assignment of benefits.

Notice of Privacy Practice:

I acknowledge that I have been given the Andover Family Medicine's Notice of Privacy Practices. I understand that if I have questions or complaints I may contact the office manager.

For Medical Card Holders Only:

This constitutes advance notice to you, the beneficiary, that if all program requirements are met by Andover Family Medicine, and payment is not made by KMAP, you may be held responsible for the charges if your services are not covered by KMAP.

Patient/Guarantor/Guardian Signature

Date

Printed Name



Permission to Disclose Information For Care & Notification Purposes

By my signature below, I (or my guardian/legal representative) authorize Andover Family Medicine and its authorized representative(s) to disclose the following Protected Health Information to those persons I have designated as being involved in my health care.

_____ **Appointment Times & Dates** _____ **Billing & Payment Information**

_____ **Test that have been performed** _____ **Tests to be performed**

_____ **Test Results** _____ **Plans of Care**

_____ **Information regarding Medications**

_____ **All information except that listed below:**

_____ **I have reviewed the above information and do not wish to designate anyone at this time.**

The Protected Health Information identified above may be released to those individuals listed below:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand this authorization will remain in effect until specifically withdrawn by me or the authorized representative signing this form.

Patient Name (Printed)

D.O.B.

Patient (Legal Guardian) Signature

Relationship

Date



Authorization For Use Or Disclosure of Protected Health Information (PHI)

Instructions:

- 1. Sections 1-6 must be completed. If any section is not complete, this authorization will be considered incomplete and not valid.
2. Please print legibly.
3. Refer to Andover Family Medicine Notice of Privacy Practice for additional information.

Section 1 - Demographic

Patient name: Birth Date:
Name at time of treatment: Social Security #:
Patient Street Address:
City: State: Zip Code:
Telephone Number - Home: Cell: Work:

Section 2 - Type of access requested

Copies of Records Inspection of Records

Treatment dates:

Please describe what specific PHI may be used or disclosed:

Progress Notes Lab Imaging Entire Record
Medication record Nursing note Immunizations Other
Operative Report H&P Consult Report
Physician Orders ER Report EKG

Section 3 - Identification of Entity Authorized to disclose PHI

I hereby authorize (Facility, Covered Entity, Persons or Class of Persons) (Phone Number) (Fax Number)

(Address) (City, State, Zip Code)
to disclose medical records information and/or protected health information of the patient listed above to: Andover Family Medicine, 105 S. Andover Rd, Suite D, Andover, KS 67002, Ph 316-7335120, Fax 316-733-1280.

Section 4 - Expiration

This authorization shall expire upon this date: (Not to exceed 1 year.)

Section 5 - Purpose

Purpose for use or disclosure:

Section 6 - Statements of Understanding

- I understand the potential for PHI to be redisclosed by the recipient and may no longer be protected by federal privacy rules.
I understand that I may revoke this authorization at any time by delivering a written revocation to the Office Manager.
If I revoke this authorization, it will have no effect on actions already taken in reliance of this form.
I understand that I may refuse to sign this form. If I do not sign, my health care or payment for health care will not be affected.
I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or I am authorized to "Act on behalf of the patient as the patient's personal representative."
Applicable fees may apply.

Signature of patient/legal representative: Date:

Printed Name of representative: Relationship:

TO BE COMPLETED BY OFFICE STAFF

I.D. verified by: Date:

Information sent by: Date:



ANDOVER
FAMILY
MEDICINE

Name: _____ Age: _____

Past Medical History

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> STD history |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Irritable Bowel |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Enlarged Prostate (BPH) |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Migraines | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Disease | _____ |

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Current Medications

Name of Drug	Strength of Drug	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

*****please list all medications including over the counter and herbal supplements

Drug Allergies/Intolerances: Yes No If yes, please list : _____

Name of Pharmacy: _____ Location: _____

Do you prefer 30 or 90 days for maintenance prescriptions? _____

Do you use a mail order pharmacy? _____ Location: _____

Name: _____

Family History

	If Living		If Deceased	
	DOB	Health Conditions	DOB	Cause
Mother				
Father				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				
Siblings				
Children				

Number of brothers: _____ Number of brothers living: _____ Number of brothers deceased: _____
Number of sisters: _____ Number of sisters living: _____ Number of sisters deceased: _____
Numbers of sons: _____ Number of daughters: _____ Healthy: Yes No

Social History

Do you smoke? Yes No
If yes, how many packs per day? _____
Are you exposed to smoke? Yes No
Did you smoke in the past? Yes No
Do you use chewing tobacco? Yes No
Do you drink caffeine? Yes No
If yes, how often? _____

Do you drink alcohol? Yes No
If yes, amount/frequency? _____
Do you exercise? Yes No
Are you sexually active? Yes No
Smoke detector in home? Yes No
Do you have pets? Yes No
If yes, what type? _____

Relationship status: Single, never married Married Partner
 Divorced Widowed Other: _____

Current Occupation: _____

Immunizations/Preventive Health

Date of last mammogram: ____/____/____ Date of last bone density: ____/____/____
Date of last dental exam: ____/____/____ Date of last eye exam: ____/____/____
Date of last chest x-ray: ____/____/____ Date of last prostate exam: ____/____/____
Date of last pap smear: ____/____/____
Have you ever had an abnormal pap smear? Yes No ____/____/____
Have you had a colonoscopy? Yes No ____/____/____
Have you had the pneumonia vaccination? Yes No ____/____/____
Have you had the cervical cancer vaccination? Yes No ____/____/____
When was your last tetanus immunization? Year _____

Please list below any other concerns or items not addressed above:

Name: _____

Review of Systems – Please mark any current symptoms.

Allergy:

- Itchy eyes
- Nasal Congestion
- Rash
- Sneezing

Constitutional:

- Fever
- Chills
- Weight Loss
- Weight Gain
- Weakness
- Fatigue

Cardiology:

- Chest Pain
- Palpitations
- Fatigue
- Leg Edema
- Short of air

Dermatology:

- Rash
- Mole
- Hives
- Dry skin
- Skin Cancer

Endocrinology:

- Excessive thirst
- Excessive hunger
- Frequent urination
- Heat intolerance
- Cold intolerance
- Hair Changes

Ear, Nose, & Throat:

- Nasal Drainage
- Sore throat
- Hoarseness
- Sinus Pain
- Teeth Pain
- Ringing in the ear
- Loss of hearing

Male Reproductive:

- Erectile dysfunction
- Decreased libido
- STD's
- Burning urination

Female Reproductive:

- LMP: _____
- Irregular cycles
- Vaginal discharge
- Pelvic pain
- Pain with sex
- Painful periods
- Breast pain
- Nipple discharge

Gastroenterology:

- Nausea
- Vomiting
- Difficulty in swallowing
- Heartburn
- Constipation
- Diarrhea
- Blood in stool
- Hemorrhoids

Hematology:

- Swollen glands
- Fatigue
- Easy bruising
- Varicose veins

Musculoskeletal:

- Joint pain
- Joint stiffness
- Joint swelling
- Back pain
- Carpal tunnel
- Fractures
- Osteoporosis

Neurology:

- Headache
- Tingling
- Numbness
- Visual changes
- Dizziness
- Memory loss
- Seizures
- Gait problems
- Sleep problems

Ophthalmology:

- Blurred vision
- Eye redness
- Eye irritation
- Eye drainage
- Eye pain

Psychology:

- Depression
- Anxiety
- Hallucinations
- Suicidal thoughts
- History of abuse
- Eating disorder

Respiratory:

- Persistent cough
- Chest congestion
- Wheezing
- Shortness of air
- Tobacco use

Urology:

- Painful urination
- Frequency
- Blood in urine
- Incontinence
- Nocturia
- History of UTI's
- Kidney stones