

# AFM

## ARBOR FAMILY MEDICINE PATIENT INFORMATION FORM

*Todays Date:* \_\_\_\_\_ *Patient #* \_\_\_\_\_

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**PATIENT'S NAME**

(LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (M.I.) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

EMPLOYER \_\_\_\_\_  
(NAME) (ADDRESS) (CITY/ST/ZIP)

OCCUPATION \_\_\_\_\_ Work Phone \_\_\_\_\_ MAY WE CONTACT YOU AT WORK? Y N

Email \_\_\_\_\_

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**PARENT/GUARDIAN/SPOUSE**

(LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (M.I.) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

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**PRIMARY MEDICAL INSURANCE** Date of Accident (If Applicable) \_\_\_\_\_

(Primary Insurance Company Name) (ID#) (Group#)

(Address) (City/State/Zip) (Phone)

(Policy Holder Name) (ID#) (Date of Birth)

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**WORKERS COMPENSATION (If applicable)** Date of Injury: \_\_\_\_\_

(Insurance Company Name) (Claim #) (Adjuster Name and Phone)

Has and Incident Report been filed with your employer? \_\_\_\_\_

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**SECONDARY MEDICAL INSURANCE**

(Primary Insurance Company Name)	(ID#)	(Group#)
(Address)	(City/State/Zip)	(Phone)
(Policy Holder Name)	(ID#)	(Date of Birth)

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**EMERGENCY CONTACT INFORMATION**

(Name)	(Phone)	(Relationship)	
(Address)	(City)	(State)	(Zip)

**AGREEMENT TO PAY FOR TREATMENT**

I, the responsible party, hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. I further understand that if I do not show for an appointment or do not give 24 hours notice to Arbor Family Medicine, PC when canceling an appointment I may be responsible for charges up to the potential cost of the visit.

**X** \_\_\_\_\_  
RESPONSIBLE PARTY DATE

**RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER**

I, the hereby authorize Arbor Family Medicine, PC and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.  
I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.  
I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.  
I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.  
I, authorize and request that payment of any third party or insurance company benefits be made directly to Arbor Family Medicine, PC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

**X** \_\_\_\_\_  
RESPONSIBLE PARTY DATE

- Patients with Health Insurance should plan to present their insurance card at each visit.
- Patients are responsible for payment of copay and coinsurance before each visit. If copay is not paid, patient may be required to reschedule the appointment.
- Patient is responsible for all labwork and must be prepared to tell the AFM staff which lab their insurance requires them to use. If presenting new insurance information on the date labs are drawn the patient should inform the person drawing the labs. AFM will not be able to make changes to the lab company once the lab leaves our office for processing.

NAME \_\_\_\_\_

DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (O) \_\_\_\_\_

OCCUPATION / EMPLOYER \_\_\_\_\_ STUDENT: FT PT N/A

INSURANCE # \_\_\_\_\_

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

- |                |                   |                   |                |       |
|----------------|-------------------|-------------------|----------------|-------|
| 1) EPILEPSY    | 6) THYROID        | 11) OSTEOPOROSIS  | 16) ALCOHOLISM | _____ |
| 2) MIGRAINE    | 7) HAYFEVER       | 12) ARTHRITIS     | 17) CANCER     | _____ |
| 3) MENTAL ILL. | 8) ASTHMA         | 13) HEART DISEASE | 18) _____      | _____ |
| 4) GLAUCOMA    | 9) ANEMIA         | 14) STROKE        | 19) _____      | _____ |
| 5) DIABETES    | 10) BLEEDS EASILY | 15) HYPERTENSION  |                | _____ |

**HOSPITAL ADMISSIONS**  
*not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

VACCINE

TEST/EXAM

_____	_____	TETANUS/Td	RECTAL / STOOL
_____	_____	FLU	CHOLESTEROL
_____	_____	PNEUMONIA	EYE
_____	_____	HEPATITIS	
_____	_____	TUBERCULOS	

**MEDICAL HISTORY** Mark (C) for current problems. Check (if) and indicate age when you had any of the following symptoms or diseases.

MAIN PROBLEMS 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

- |  |   |   |  |   |  |
|--|---|---|--|---|--|
| <input type="checkbox"/> Decreased Hearing                               | <input type="checkbox"/> Loss of Appetite-Recent                                | <input type="checkbox"/> Cancer                                     | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Polio          | <input type="checkbox"/> Mumps           |
| <input type="checkbox"/> Ringing in Ear                                  | <input type="checkbox"/> Difficulty Swallowing                                  | <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Measles   | <input type="checkbox"/> German Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Ear Infections - frequent                       | <input type="checkbox"/> Indigestion or Heartburn                               | <input type="checkbox"/> Thyroid Disease                            | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Herpes          |
| <input type="checkbox"/> Dizzy Spells                                    | <input type="checkbox"/> Persistent Nausea / Vomiting                           | <input type="checkbox"/> Convulsions / Seizures                     | <input type="checkbox"/> Contact with Blood or Body Fluids   |   |  |
| <input type="checkbox"/> Failing Vision D Eye Pain                       | <input type="checkbox"/> Peptic Ulcers  | <input type="checkbox"/> Stroke                                     |  |   |  |
| <input type="checkbox"/> Double or Blurred Vision                        | <input type="checkbox"/> Abdominal Pain- chronic                                | <input type="checkbox"/> Tremor / Hands Shaking                     | <input type="checkbox"/> Alcohol _____ oz. per week  |   |  |
| <input type="checkbox"/> Eye Infections - frequent                       | <input type="checkbox"/> Gall Bladder Trouble                                   | <input type="checkbox"/> Muscle Weakness                            | <input type="checkbox"/> Smoking _____ cig. per day _____ #yrs.                                      |   |  |
| <input type="checkbox"/> Nose Bleeds - recurrent                         | <input type="checkbox"/> Jaundice / Hepatitis                                   | <input type="checkbox"/> Numbness / Tingling                        | <input type="checkbox"/> Coffee / Tea _____ cups per day   |   |  |
| <input type="checkbox"/> Sinus Trouble                                   | <input type="checkbox"/> Change in Bowel Habits                                 | Sensations  |  |   |  |
| <input type="checkbox"/> Sore Throats - frequent                         | <input type="checkbox"/> Diarrhea D Constipation                                | <input type="checkbox"/> Headaches - frequent                       | <b>FEMALES - Please complete</b>   |   |  |
| <input type="checkbox"/> Hayfever / Allergies                            | <input type="checkbox"/> Diverticulosis D Crohn's / Colitis                     | <input type="checkbox"/> Arthritis / Rheumatism                     | Menstrual Flow:  |   |  |
| <input type="checkbox"/> Hoarseness - prolonged                          | <input type="checkbox"/> Bloody or Tarry Stools                                 | <input type="checkbox"/> Back Pain - recurrent                      | <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain / Cramps |   |  |
| <input type="checkbox"/> Pneumonia / Pleurisy                            | <input type="checkbox"/> Hemorrhoids  | <input type="checkbox"/> Bone Fracture / Joint Injury               | Days of Flow _____ Length of Cycle _____   |   |  |
| <input type="checkbox"/> Bronchitis / Chronic Cough                      | <input type="checkbox"/> Hernia   | <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis | Date -1 st day of last period _____  |   |  |
| <input type="checkbox"/> Asthma / Wheezing                               | <input type="checkbox"/> Urine Infections - frequent                            | <input type="checkbox"/> Foot Pain                                  | <input type="checkbox"/> Pain / Bleeding during or after sex   |   |  |
| <input type="checkbox"/> Shortness of Breath:                            | <input type="checkbox"/> Blood in Urine   | <input type="checkbox"/> Cold Numb Feet                             | Number of:   |   |  |
| <input type="checkbox"/> on Exertion <input type="checkbox"/> Lying Flat | <input type="checkbox"/> Urination _____ Overnight, > than                      | <input type="checkbox"/> Rashes <input type="checkbox"/> Hives      | Pregnancies _____ Abortions _____  |   |  |
| <input type="checkbox"/> Chest Pain                                      | twice <input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control | <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema  | Miscarriages _____ Live Births _____   |   |  |
| <input type="checkbox"/> High Blood Pressure                             | <input type="checkbox"/> Decrease in Force / Flow                               | <input type="checkbox"/> Sleeping - difficulty                      | Birth Control Method _____   |   |  |
| <input type="checkbox"/> Heart Murmur                                    | <input type="checkbox"/> Kidney Stones  | <input type="checkbox"/> Nervousness                                | B.C. Pill (name) _____   |   |  |
| <input type="checkbox"/> Irregular Pulse                                 | <input type="checkbox"/> Venereal Disease                                       | <input type="checkbox"/> Depression                                 | <input type="checkbox"/> Flushing / Menopause  |   |  |
| <input type="checkbox"/> Palpitations                                    | <input type="checkbox"/> Urethral Discharge                                     | <input type="checkbox"/> Memory Loss                                | Date of last PAP Test _____  |   |  |
| <input type="checkbox"/> Swollen Ankles                                  | <input type="checkbox"/> Chronic Fatigue  | <input type="checkbox"/> Moodiness - excessive                      | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                    |   |  |
| <input type="checkbox"/> Fainting Spells                                 | <input type="checkbox"/> Weight Loss - recent                                   | <input type="checkbox"/> Phobias                                    | Date of last Mammogram _____   |   |  |
| <input type="checkbox"/> Leg Pain - walking                              | <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Mental Illness                             | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                    |   |  |
| <input type="checkbox"/> Varicose Veins / Phelbitis                      |   |   |  |   |  |

**SYNOPSIS**

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## ***Notice of Privacy Practices***

April 14, 2003

### **Arbor Family Medicine**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment means** providing, coordinating, managing health care and /or related services by one or more health care providers. Examples of treatment would include office visits, x-rays, wart removal, office surgery etc.
- **Payment means** such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your medical services.
- **Health Care Operations include** the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information (i.e the Centers for Disease Control) or to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH

INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to request a copy of your PROTECTED HEALTH INFORMATION (charges for the copying are subject to state requirements).
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices or to file a complaint, please contact:**

Wendy Plummer  
Administrative Director/HIPAA Compliance Officer  
Arbor Family Medicine, PC  
3655 E 104th Avenue  
Thornton, CO 80233  
Phone: 303.254.8500

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
877-696-6775 (toll-free)

**ACKNOWLEDGMENT OF RECEIPT OF  
PRIVACY PRACTICES**

**I have received a copy of Arbor Family Medicine, PC's Notice of Privacy Practices.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Representative (if minor)



*West Office*  
 10835 Dover St, Suite 1100  
 (108<sup>th</sup> and Wadsworth Blvd)  
 Westminster, CO 80021  
 P: 303.431.5409  
 F: 303.431.1914

**Arbor Family Medicine, PC**

Philip J. Rosenblum, MD  
 Suzanne C. Nash, MD  
 Kenneth W. Hahn, DO  
 Amarbr "Robina" Sidhu, MD

*East Office*  
 3655 E. 104<sup>th</sup> Ave  
 (104<sup>th</sup> and Colorado Blvd)  
 Thornton, CO 80233  
 P: 303.254.8500  
 F: 303.453.4994

Melanie Anderson, PA-C

Gina Bolinger, PA-C

Jeffrey Bundy, PA-C

Erin Ressler, PA-C

**Patient Request for Confidential Communication**

Please fill out the top part of this form for any person that you would like us to speak to regarding your care. This will allow us to give this person(s) test results, communicate information from your office visit and other Protected Health Information. We **will not** release a copy of your medical record to this person(s) without your specific written request. This request may be revoked at any time, by written or verbal request.

I \_\_\_\_\_ hereby request confidential communication of my protected health information to the following individual(s):

Communications with the patient named above can be directed to:

**Additional Point of Contact:** \_\_\_\_\_

**Contact Address:** \_\_\_\_\_

**Contact Phone:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Methods of Communication (Please Circle):**      **Phone**      **Mail**

Patient Signature: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date: \_\_\_\_\_

**West Office**  
10835 Dover St, Suite 1100  
(108<sup>th</sup> and Wadsworth Blvd)  
Westminster, CO 80021  
P: 303.431.5409  
F: 303.431.1914

## Arbor Family Medicine, PC



**East Office**  
3655 E. 104<sup>th</sup> Ave  
(104<sup>th</sup> and Colorado Blvd)  
Thornton, CO 80233  
P: 303.254.8500  
F: 303.453.4994

### AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_ Fax # of Physician: \_\_\_\_\_

Reason for Records Release \_\_\_\_\_

**These records are to be sent to Arbor Family Medicine at the Thornton / Westminster Office at the address above.**

Patient's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

*The type and amount of information to be disclosed is initialed as follow:(specify dates where appropriate)*

\_\_\_\_ X-Ray films (Specify type/date)  
\_\_\_\_ Immunizations  
\_\_\_\_ Most recent 3 years of Records  
\_\_\_\_ Entire Medical Record

\_\_\_\_ Substance and Drug Abuse, if any  
\_\_\_\_ AIDS/HIV, if any  
\_\_\_\_ Genetic testing, from date  
\_\_\_\_ Psychological or psychiatric conditions, if any

Other: \_\_\_\_\_

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company.

I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for any copying fees. Shipping and applicable sales tax may also be charged.

Patient name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient's (or Representative) Signature: \_\_\_\_\_

Patient's Representative (Print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_