FRONTIER FAMILY PRACTICE
Health History

PATIENT NAME: ______________________

REASON FOR VISIT:____

Who is your Primary Care Provider: ____

PAST MEDICAL HISTORY

Your health history is very important in allowing us to provide the best care possible for you. Please remember that all information you share with us will be kept confidential. Please circle any of the issues below that have affected your health. Use the blank lines to add anything else you think is important for us to know.

General Health: *unintentional weight change, fatigue, chronic pain*____
____

Eyes, Ears, Nose, Sinuses, Mouth, Throat: ____
____

Brain/spine: *headaches, migraines, seizures, neck pain, back pain, stroke*__________________________________
____

Lungs: *asthma, COPD, emphysema, sleep apnea*____
____

Heart/veins: *chest pain, MI, congestive heart failure, abnormal EKG, varicose veins, high blood pressure, high cholesterol, leg swelling*____
____

Bowels: *difficulty swallowing, heartburn, ulcers, blood in stools, chronic constipation or diarrhea, colitis, irritable bowel*
____

Skin: *eczema, psoriasis, skin cancer*____
____

Bones/Muscles: *fractures, joint surgeries, arthritis, osteoporosis*____
____

Emotions: *anxiety, depression*____
____

Reproductive: *abnormal PAP, infertility, impotence*____
____

Endocrine: *diabetes, thyroid disease*____
____

Addictions: *alcohol, food, tobacco, pain medications, drugs*____
____

Blood: *anemia, blood clots*____
____

Kidneys/bladder: *kidney disease, chronic urinary tract infections, prostate enlargement, incontinence*_______________
____

Cancers: ____
____

Any Other Concerns:____

Surgeries/Hospitalizations
Have you ever had surgery, a serious accident or injury, or hospitalization for any other reason? ▪ No ▪ Yes *If yes, please provide details, dates, surgeons:* ____

____

____

Has any medical or surgical treatment ever been recommended and not performed? ▪ No ▪ Yes *If yes, please provide details:*____

SOCIAL HISTORY
Marital status: Single Married Widowed Divorced Living with S.O.
Do you live alone? Yes No If no, with whom do you live______________________________
Work status: Working Retired Disabled Student What type of work do/did you do? ______________________

Do you now, or have you in the past, used tobacco of any kind? Use now Quit (when) Never used
Type: Cigarettes Smokeless (chew) How much per day?________________________ How long? _____________
How many drinks of alcohol do you average daily? _______ Weekly? ________
Do you use recreational drugs, i.e. marijuana, cocaine, stimulants? Yes No Which type?________________________

Are you up to date on the following vaccinations?: *Influenza* __________ *Pneumonia* ___________ *Tetanus* __________

FAMILY HISTORY
Have any of the following affected your parents, siblings or children?
Heart disease: Yes No______________________________
High Blood Pressure: Yes No______________________________
Cancer: Yes No_ ______________________________
Diabetes: Yes No______________________________
Thyroid Disease: Yes No______________________________
Kidney: Yes No______________________________
Stroke: Yes No______________________________

ALLERGIES
Do you have any of the following allergies? Please list all allergies and tell us what reaction you had.
Medications:______________________________

____
Foods:______________________________

____
Environment (cats, grasses, pollens, etc.)______________________________

____

MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS
Please list all medications – prescription and non-prescription – you are currently taking. Doses are important.

MEDICATION	DOSE	HOW OFTEN	FOR HOW LONG	FOR WHAT REASON

Which pharmacy(ies) do you use?______________________________

Frontier Family Practice

201 1st Ave North - Fairfield, MT 59436
Phone (406) 467-3447 Fax (406)467-3407

PATIENT REGISTRATION

(Please print clearly)

Full Name____DOB_______________Male/Female
Address____________________________________City/State/Zip___________________________
Home Phone ______________Cell Phone_______________Work Phone_____________________
Best means of contacting you: Home Phone Work Phone Cell Phone Email
Social Security #________________________Employer__________________________________
Pharmacy of Choice_______________________Occupation_______________________________

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race
Ethnicity: ☐ Hispanic ☐ Non Hispanic
Language: ☐ English ☐ Indian ☐ Spanish ☐ Russian ☐ Tagalog ☐ Thai ☐ Other____

Parent and/or Spouse's Name________________________________DOB____________________
Social Security #___________________________________Phone #_________________________
Employer____Employer Phone___________________

PRIMARY INSURANCE INFORMATION

Insurance Company________________________Policy Holder______________________________
CoPay____________Social Security #_________________________Date of Birth_______________
Subscriber #___________________________________Group #______________________________

SECONDARY INSURANCE INFORMATION

Insurance Company________________________Policy Holder______________________________
CoPay____________Social Security #________________________Date of Birth________________
Subscriber #_____________________________________Group #____________________________

Primary Provider____________________________Referring Provider_________________________

<u>INFORMED CONSENT FOR TREATMENT</u>

I understand that I am now under the care and supervision of the providers of Frontier Family Practice. I understand that it is the responsibility of Frontier Family Practice and its staff to carry out the instructions of the providers. I consent to medical services rendered to me and the expressed or implied instruction of my provider. I understand that any services furnished to me outside of the scope of any instruction, express or implied, of my provider or designee are not performed on behalf of , or at the direction of Frontier Family Practice.

<u>Assignment and Release</u>

I certify that I, and/or my dependent(s) have insurance coverage with above listed insurance company and assign directly to Frontier Family Practice all insurance benefits. If any otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges on all insurance submissions. The above named facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or in one year from the signed date below.

____

Signature of Patient or Patient Representative **Date**

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<u>Prescription Consent</u>
I give my consent to have Frontier Family Practice obtain my prescription history from external sources.

____

Signature of Patient or Patient Representative   Date

<u>RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM</u>

I, ______________________________, have received a copy of the Frontier Family Practice's Notice of Privacy practices.

Signature:_______________________________________Date:______________

EMAIL AUTHORIZATION AGREEMENT

Frontier Family Practice may choose to discontinue e-mail communication at any time.

<u>Privacy and Security of E-mail</u>

Do not use e-mail to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, and e-mail sent on your employer's system may be viewed by your employer.

Frontier Family Practice cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail.

This document along with Frontier Family Practice "Notice of Privacy Practices" constitutes a notice of privacy practice for e-mail use.

<u>Authorization to use e-mail</u>

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with my physician, and his/her associates, technicians and other healthcare providers.

You will be given a copy of this signed form to keep for your records.

Patient Signature____Date______________

Patient e-mail address____

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Contact Consent

With consent, Frontier Family Practice, and/or representatives thereof may call my home or other designated location and may leave messages on a voicemail or in person in reference to any items that assist our office in carrying out treatment payment options which may include but are not limited to – procedures done during visit and diagnosis's used for billing purposes, insurance items including denial reasons, and balance of account.

Home/Cell Phone______________________Work Phone_______________________

- ◻ OK to leave a detailed message
- ◻ OK to leave message with call back number only
- ◻ OK to leave detailed message with person
- ◻ OK to leave message with detailed information at work #
- ◻ OK to fax to this number___________________
- ◻ Leave message with call back number only

Written/Electronic Communications

- ◻ OK to mail to my home address
- ◻ OK to mail to my work office
- ◻ OK to send via my request to the following email_______________________________

I acknowledge that this information will only be sent upon request and is not guaranteed to be sent securely._________ (Initials)

Persons that are **ABSOLUTELY NOT** to have my PHI

____

____

Persons who **ARE ABLE** to discuss my PHI

____

____

By signing this form, I am consenting to Frontier Family Practice, and/or representatives to use and disclose my PHI to carry out treatment Payment Options. I may revoke my consent in writing except in the extent that the practice has already made disclosures in reliance upon my prior consent. This form will remain in effect until otherwise noted.

____

Signature of Patient/Legal Guardian   Date

____

Printed Name of Patient

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RECEIPT OF COLLECTIONS NOTICE

I, ______________________, understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50%, the additional cost, and charges listed above represent the actual costs incurred by Frontier Family Practice to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

____

Signature of Patient/Legal Guardian **Date**

____

Printed Name of Patient