FRONTIER FAMILY PRACTICE
Child 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, sleep apnea, inhaler*_____

_____

Heart/veins: *palpitations, abnormal EKG, high blood pressure, high cholesterol, leg swelling*

_____

_____

Bowels: *difficulty swallowing, heartburn, ulcers, blood in stools, chronic constipation or diarrhea,*

_____

Skin: *eczema, psoriasis, skin cancer*_____

_____

Bones/Muscles: *fractures, joint surgeries*_____

_____

Emotions: *anxiety, depression*_____

_____

Girls: Menstrual Cycle – has it started/when?_____

_____

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: _____

_____

Immunizations Up to Date? ___Yes ___No

Birth: _____Birth Weight @ _____ Weeks Gestation _____ Apgar Score _____ NICU Time

_____Vaginal Birth_____Cesarean _____Induced _____Spontaneous

Birth Complications:_____

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

Who does the Child live with?_____

School status: What school do you attend?_____ Grade?_____

Sports:_____ Hobbies:_____

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? _____

Anyone smoke in the home?_____

How many drinks of alcohol do you average daily? _____ Weekly? _____

Do you use recreational drugs, i.e. marijuana, cocaine, stimulants? Yes No Which type?_____

Any risk for lead based paints in the home (homes built before 1978)?_____

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 #_____ Pharmacy of Choice_____

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 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_____

INFORMED CONSENT FOR TREATMENT

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.

Assignment and Release

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 Legal Guardian **Date**

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Prescription Consent

I give my consent to have Frontier Family Practice obtain my prescription history from external sources.

_____

Signature of Patient or Legal Guardian **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

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.

Privacy and Security of E-mail

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.

Authorization to use e-mail

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/Legal Guardian 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/Legal Guardian and Relationship

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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