



**FPG**

*Family Physicians Group*

**HOW DID YOU HEAR ABOUT FAMILY PHYSICIANS GROUP?**

Office Location: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

***Check all that apply:***

- Newspaper  *Which?* \_\_\_\_\_
- Radio Commercial  *Which?* \_\_\_\_\_
- Television Commercial  *Which?* \_\_\_\_\_
- Mail/Postcard
- Flyers
- Public Display
- Health Fair/Seminar
- Marketing Representative
- Insurance Representative  *Which?* \_\_\_\_\_
- Friends and Family
- Another physician  *Who?* \_\_\_\_\_
- Other  *Explain* \_\_\_\_\_



Family Physicians Group

## FPRx Enrollment and Prescription Form

Please complete this form in full. Print clearly and carefully.

### PERSONAL INFORMATION

Name/Nombre		Date of Birth/Fecha de Nacimiento
Address/Dirección		Address 2/Dirección 2
City/Ciudad	State/Estado	ZIP Code/Código Postal
Social Security Number/Seguro Social	Home Phone/Numero de Casa	Cell Phone/Celular
Health Plan/Nombre Plan de Salud	Plan ID/Numero Identificador	Group/Código Grupo

I DECLINE. Please, do not enroll me in Family Physicians Pharmacy (FPRx).

Yes, please sign me up for Family Physicians Rx Pharmacy Mail Order Services.  
*Deseo Participar Servicio de Entrega Medicamentos por correo.*

Yes, enroll me in Automatic Refill so my prescriptions arrive on time each month.  
*Deseo participar "Refill" Automático de Medicamentos.*

Allergies/Alergias

- None     Aspirin     Sulfa     Penicillin  
 Other (Please define):

Patient Signature/Firma Paciente





Family Physicians Group

## Health Care Services Agreement

The undersigned hereby request and consent to the services of Family Physicians Group, including examination, treatment and other procedures deemed appropriate from this date onwards.

I agree to be responsible for all fees and costs related to these services, either directly or through my health care insurance provider. In this regard, I authorize the release of any information required by such provider for the processing of claims for payment. I further authorize payment of benefits directly to Family Physicians Group

It will be my responsibility to notify Family Physicians Group of any insurance that I have and any changes I make with my insurance plans; plus, to provide them with my insurance cards for copying.

I understand that I will be individually responsible for fees incurred, including co pays and deductibles, regardless of insurance. I further understand that Family Physicians Group will make every attempt to collect payments from the insurance provider that I have and will bill me for any balance due after insurance has made their determination of payment. This balance will be paid by me within 30 days of receiving my statement.

I understand that I will be responsible for any additional costs to collect my past dated account, but also any additional costs that may incur for the collection of my account, such as interest, litigation cost and attorney's fees if so necessary.

### Person(s) Responsible for Bill

*(Other than Medical Insurance):*

Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_\_  
Date

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

*(If patient is a minor, signature of Parent / Legal Guardian)*



Family Physicians Group

Acknowledgement for Advanced Directives

As your Medical Doctor, we need to know if you have executed an Advance Medical Directive:

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, this Directive is in the form of:

- \_\_\_\_\_ A Living Will
\_\_\_\_\_ A Do Not Resuscitate Order
\_\_\_\_\_ A Health Care Surrogate
\_\_\_\_\_ An Anatomical Donor Form

If you answered YES, could you please provide us with a copy of the forms at your earliest convenience, sign below, and proceed to the next page.

If you answered NO, please read the following statement and sign below.

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about their health care will still be respected, Advance Directives were created. These directives outline in writing your wishes regarding future medical treatment. Without any written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. There are several types of advance directives:

Living Will: It is a written statement of the kind of medical care you want or do not want if you become unable to make your own decisions.

Health Care Surrogate: This document names another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will.

Anatomical donor form: It is a document that indicates your wish to donate, at death, all or part of your body. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card, signing a uniform donor form, or expressing your wish in a living will.

DNR form: This is a yellow form that identifies people who do not wish to be resuscitated in the event that they stop breathing of their heart stops beating.

The Advance Directives come into effect only if you become incapacitated and you can change it at any time. As long as you are capable, you should discuss your expectations for future medical care with your physician. However, before you fill out the Advance Directives you may also want to talk to your family, friends, lawyer, or spiritual advisor.

\_\_\_\_\_ Check here if you would like to receive advance directive forms from our office.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
SS#



Family Physicians Group

# Authorization to Obtain or Release Protected Health Information

I, \_\_\_\_\_ Hereby authorize Family Physicians Group to

\_\_\_\_\_ Release copies  
\_\_\_\_\_ Obtain Records Of the medical records of \_\_\_\_\_

To/From: \_\_\_\_\_  
Name of individual, healthcare facility or agency

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**For the Purpose of:** \_\_\_\_\_ Continued Treatment \_\_\_\_\_ Personal Records \_\_\_\_\_ Transfer In/Out  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_

Date(s) of Service: From: \_\_\_\_\_ To: \_\_\_\_\_

This authorization will expire on the following date, event or condition: \_\_\_\_\_  
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my records be released without my written authorization, except as otherwise required by law. I understand that any disclosure of information Family Physicians Group may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

**Place your initials by each item to be released or obtained:**

\_\_\_\_\_ Complete record \_\_\_\_\_ All diagnostic test results \_\_\_\_\_ Pathology/Operative report(s)  
\_\_\_\_\_ Or \_\_\_\_\_ Therapy Records \_\_\_\_\_ Other (please specify) \_\_\_\_\_  
\_\_\_\_\_ Abstract Records \_\_\_\_\_ Consultation/Progress Note(s) \_\_\_\_\_ Labs  
\_\_\_\_\_ Medication History \_\_\_\_\_ Radiology only \_\_\_\_\_ Other (please specify) \_\_\_\_\_

**In addition, place your initials by each specific item: (if applicable)**

\_\_\_\_\_ Mental Health \_\_\_\_\_ HIV Testing \_\_\_\_\_ Genetic Counseling/Testing Information  
\_\_\_\_\_ Drug and/or alcohol \_\_\_\_\_ AIDS Information

\_\_\_\_\_  
Patient/Legal Representative or parent/legal Guardian Signature Date of Authorization

\_\_\_\_\_  
Date of Birth Social Security Number Type of ID Shown

\_\_\_\_\_  
Address City State Zip Code

\_\_\_\_\_  
Telephone Number Translator or Interpreter's Name

**Official Use Only:**

\_\_\_\_\_  
Name of Person Releasing Information Date  
\_\_\_\_\_  
Name of person Assisting with review  
Number of pages copied \_\_\_\_\_



Family Physicians Group

## ANNUAL HISTORY & PHYSICAL

Patient Name:		DOB:	Age:
Insurance:	Marital Status S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>	Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Primary Language:	Need of Translator: Y <input type="checkbox"/> N <input type="checkbox"/>	Occupation	

Allergies:

Current Meds:

### Family History: If any blood relative has suffered any of the following: please indicate which relative

Tuberculosis	Epilepsy	Arthritis
Stroke	Diabetes	Gout
Heart Disease	Cancer <i>Which type:</i>	Kidney Disease
Mental Illness	Allergy	Glaucoma
High Cholesterol	High Blood Pressure	Other:

### Hospital Admission & Operations


### Immunizations History - please write appropriate date

Hepatitis B	Measles	Flu	Diphtheria
Small Pox	Mumps	Pertusis	Pneumovax
Typhoid	Rubella	Tetanus	Shingles

Transfusions: Y  N  Please list:

### Please Indicate dates of your last:

Complete Physical:	Prostate Exam:	Pap Smear:
Cholesterol Check:	Colonoscopy:	Mammogram:
Eye Exam:	TB Test:	Breast Exam:
		Bone density or osteoporosis test:

### For Women Only: Gynecological and Obstetric

Age of onset menstrual period:	Frequency:	Length of period:	
Pregnancies:	# Live Births:	# Miscarriages:	# Abortions:
Prolonged or Abnormal Bleeding:	Y <input type="checkbox"/> N <input type="checkbox"/> If yes please describe:		
Leakage of Urine:	Y <input type="checkbox"/> N <input type="checkbox"/> If yes please describe:		
Pelvic Pain:	Y <input type="checkbox"/> N <input type="checkbox"/> If yes please describe:		
Abnormal Discharge:	Y <input type="checkbox"/> N <input type="checkbox"/> If yes please describe:		
History of Abnormal Pap Smear:	Y <input type="checkbox"/> N <input type="checkbox"/> If yes please describe:		



**Past Medical History – Do you have or have had any of these illnesses ?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 1. Glaucoma or Cataracts           | <input type="checkbox"/> 18. Diverticulosis or Diverticulitis | <input type="checkbox"/> 35. Gout                   |
| <input type="checkbox"/> 2. Macular degeneration            | <input type="checkbox"/> 19. Hemorrhoids                      | <input type="checkbox"/> 36. Rheumatoid Arthritis   |
| <input type="checkbox"/> 3. Frequent Ear Infections         | <input type="checkbox"/> 20. Gall Bladder Disease             | <input type="checkbox"/> 37. Osteoarthritis         |
| <input type="checkbox"/> 4. Hay Fever/ Sinus Allergies      | <input type="checkbox"/> 21. Colitis                          | <input type="checkbox"/> 38. Lupus                  |
| <input type="checkbox"/> 5. Chronic sinusitis               | <input type="checkbox"/> 22. Frequent Urine Infections        | <input type="checkbox"/> 39. Psoriasis or Eczema    |
| <input type="checkbox"/> 6. Asthma or Emphysema (COPD)      | <input type="checkbox"/> 23. Kidney Stones                    | <input type="checkbox"/> 40. Anxiety or Depression  |
| <input type="checkbox"/> 7. Chronic bronchitis              | <input type="checkbox"/> 24. Enlarged Prostate                | <input type="checkbox"/> 41. Schizophrenia          |
| <input type="checkbox"/> 8. Pneumonia                       | <input type="checkbox"/> 25. Chronic Kidney Disease           | <input type="checkbox"/> 42. Bipolar disorder       |
| <input type="checkbox"/> 9. Heart Murmur                    | <input type="checkbox"/> 26. Sexually Transmitted Disease     | <input type="checkbox"/> 43. German Measles/Rubella |
| <input type="checkbox"/> 10. High Blood Pressure            | <input type="checkbox"/> 27. Diabetes or Pre-Diabetes         | <input type="checkbox"/> 44. Chicken Pox            |
| <input type="checkbox"/> 11. Heart attack or Heart disease  | <input type="checkbox"/> 28. Thyroid Disease                  | <input type="checkbox"/> 45. Measles                |
| <input type="checkbox"/> 12. Irregular heartbeat /          |   |   |
| <input type="checkbox"/> Pacemaker                          | <input type="checkbox"/> 29. Varicose Veins/Phlebitis         | <input type="checkbox"/> 46. Scarlet Fever          |
| <input type="checkbox"/> 13. High Cholesterol               | <input type="checkbox"/> 30. Tuberculosis                     | <input type="checkbox"/> 47. Mumps                  |
| <input type="checkbox"/> 14. Acid Reflux or GERD            | <input type="checkbox"/> 31. Stroke                           | <input type="checkbox"/> 48. Polio                  |
| <input type="checkbox"/> 15. Hepatitis                      | <input type="checkbox"/> 32. Epilepsy or Seizures             | <input type="checkbox"/> 49. Rheumatic Fever        |
| <input type="checkbox"/> 16. Peptic or Stomach Ulcers       | <input type="checkbox"/> 33. Migraine Headaches               | <input type="checkbox"/> 50. Cancer:                |
| <input type="checkbox"/> 17. Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> 34. Anemia                           | Which: _____  |
| <input type="checkbox"/> Other:                             |   |   |

**Review of Symptoms – Do you have or RECENTLY had any of these symptoms ?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 1. Unusual fatigue or weakness | <input type="checkbox"/> 20. Palpitations or tachycardia        | <input type="checkbox"/> 39. Urethral Discharge         |
| <input type="checkbox"/> 2. Fever or chills             | <input type="checkbox"/> 21. Swelling of feet or legs           | <input type="checkbox"/> 40. Bruise or bleed easily     |
| <input type="checkbox"/> 3. Recent weight loss or gain  | <input type="checkbox"/> 22. Fainting Spells                    | <input type="checkbox"/> 41. Convulsions/Seizures       |
| <input type="checkbox"/> 4. Decreased Hearing           | <input type="checkbox"/> 23. Leg Pain when Walking              | <input type="checkbox"/> 42. Tremor/Hands Shaking       |
|   |   | <input type="checkbox"/> 43. Numbness/Tingling          |
| <input type="checkbox"/> 5. Ringing in Ear              | <input type="checkbox"/> 24. Loss of Appetite                   | <input type="checkbox"/> Sensation                      |
| <input type="checkbox"/> 6. Dizzy Spells                | <input type="checkbox"/> 25. Difficulty Swallowing              | <input type="checkbox"/> 44. Frequent Headaches         |
| <input type="checkbox"/> 7. Earache                     | <input type="checkbox"/> 26. Indigestion/ Heartburn             | <input type="checkbox"/> 45. Memory Loss                |
| <input type="checkbox"/> 8. Failing Vision              | <input type="checkbox"/> 27. Persistent Nausea/Vomiting         | <input type="checkbox"/> 46. Muscle Weakness            |
| <input type="checkbox"/> 9. Double or Blurred Vision    | <input type="checkbox"/> 28. Abdominal Pain                     | <input type="checkbox"/> 47. Back Pain – Recurrent      |
| <input type="checkbox"/> 10. Eye Pain                   | <input type="checkbox"/> 29. Change in Bowel Habits             | <input type="checkbox"/> 48. Bone Fracture/Joint Injury |
| <input type="checkbox"/> 11. Eye Infection              | <input type="checkbox"/> 30. Diarrhea or Constipation           | <input type="checkbox"/> 49. Joint Pain:                |
| <input type="checkbox"/> 12. Nose Bleeds                | <input type="checkbox"/> 31. Bloody or Tarry Stools             | Which: _____  |
| <input type="checkbox"/> 13. Sinus congestion or pain   | <input type="checkbox"/> 32. Jaundice ( Yellowing of skin )     | <input type="checkbox"/> 50. Cold Hands or Feet         |
| <input type="checkbox"/> 14. Sore Throat                | <input type="checkbox"/> 33. Hernia                             | <input type="checkbox"/> 51. Rashes or Itching          |
| <input type="checkbox"/> 15. Hoarseness                 | <input type="checkbox"/> 34. Painful Urination                  | <input type="checkbox"/> 52. Hives                      |
| <input type="checkbox"/> 16. Wheezing                   | <input type="checkbox"/> 35. Blood in Urine                     | <input type="checkbox"/> 53. Moodiness-Excessive        |
| <input type="checkbox"/> 17. Shortness of breath        | <input type="checkbox"/> 36. Overnight Urination-More than 2    | <input type="checkbox"/> 54. Nervousness                |
| <input type="checkbox"/> 18. Chronic cough              | <input type="checkbox"/> 37. Incontinence or dribbling of urine | <input type="checkbox"/> 55. Depression                 |
| <input type="checkbox"/> 19. Chest pain or tightness    | <input type="checkbox"/> 38. Decrease in force of Urination     | <input type="checkbox"/> 56. Phobias                    |

Do you wear or use? :  Eyeglasses or contact lenses  Dentures  Hearing aides

Do you wear seat belts? **Yes No** | Use drugs? (Marijuana, Cocaine, Crack, etc...) **Yes No**

Do you drink beverages with caffeine? **Yes No** | Is there a gun in your home? **Yes No**

Do you smoke? **Yes No** | Is it unloaded & out of children's reach? **Yes No**

Do you drink alcohol? **Yes No** | Comments:



Family Physicians Group

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by the "practice" in order to carry out treatment, payment, or health care operations.

The practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the practice does change the terms of its Notice of Privacy Practice, patient may obtain a copy of the revised notice from our Office Manager

Patient retains the right to request that the practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to such requested restrictions; however, if the practice does agree to patient's requested restriction(s); such restrictions are then binding on the practice.

Patient acknowledges and agrees that the practice may disclose patient's protected health information and patient medical record information to the following individuals who are either the patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the patient:

Three horizontal lines for listing individuals.

The patient agrees that the practice may disclose the following types of information contained in the patient's medical records (please initial the appropriate categories listed below):

Two columns of checkboxes for medical record categories: Home Phone #, Home Address, Occupation, Name of Employer, Visit Notes, Hospital Notes, Prescription Information, Patient History, Office Address, Office Phone #, Spouse's Name, Spouse's Office Phone #, Test Results, Other.

Patient agrees and consents to the practice releasing information to patient in the following alternative manners (please initial the appropriate spaces below):

Three lines for alternative release methods: Via fax, Via regular mail, Via telephone.



Family Physicians Group

The practice may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form. If patient (or an authorized representative) signs this consent and then revokes it, the practice has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that the practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AN AUTHORIZED REPRESENTATIVE TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: \_\_\_\_\_ Time \_\_\_\_\_AM/PM

\_\_\_\_\_  
Signature of Patient (or an Authorized Representative\*)

\_\_\_\_\_  
Please Print Name

\*Please explain representative's relationship to patient and include a description of representative's authority to act on behalf of the patient:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_