House Call Connections

Confidential
Registration Information
Please Print

___ New Patient
___ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

Date ___/___/____ Email Address: ________________________ Home Phone:____________ Work Phone:_________

Last Name________________________________First Name______________________MI___ Cell Phone: __________

Street Address: ____ Mailing Address__________________________

City: ____ State ________ Zip______________

Gender: Male___ Female___ SSN: ______ - _____- _______ Birth-date ____/____/______

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other ________________

Patient Employed by: ____

Business Address____

Business Phone: __________________________________ Occupation _______________________________________

Name of Spouse/Responsible Party (If patient is minor): ____
Last First MI

Spouse/Responsible party Employed by: ____

Business Address: ____

Business Phone: __________________________________ Occupation _______________________________________

Responsible Party/Spouse SSN: _____-_____-_______

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: ___________________________ ID # ___________________________ Group # _________

*Subscriber's Name: ____ *Birth-date: ____/____/____

Insurance Address ____

Name of Secondary Insurance: ___________________________ ID # ________________________ Group # _________

*Subscriber's Name: ____ *Birth-date: ____/____/____

Insurance Address ____
*This information is required by HIPPA

In case of an emergency, who should be notified? ____

Relationship ____Phone: ____________________________

Preferred Pharmacy: _________________________________ How did you hear about us? _______________________

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ___________________________________ hereby authorize____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to _____________________ __all benefits, if any, otherwise payable to me for his/her
(Provider's Name)

services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____________________________________
(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

____ _____________________________
(Authorized Signature of Subscriber) (Date)

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to House Call Connections, LLC for any services furnished to me by House Call Connections, LLC. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

____ _____________________________________
Signature of Beneficiary Date

Financial Policy

I have read and understand the financial policies of House Call Connections, LLC. By my signature I agree to the terms outlined in the financial policies.

____ _____________________________________
Signature Date

Consent for Treatment

I (or my legal guardian/parent) authorize House Call Connections, LLC to provide medical care reasonable by today's standards.

____ _____________________________________
Signature of Patient/Legal Guardian Date

House Call Connections, LLC

15400 W. 64th Ave 9E, Suite 14 ● Arvada, CO 80007 ● 303-422-3909

Today' s Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring provider:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

NAME______________________________ DATE____________________

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				

NAME____ DATE____________________

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Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

NAME____ DATE____________________

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Visual Changes/Loss	☐ Shortness of breath	☐ Changes in muscle strength
☐ Head Injury	☐ Asthma or Emphysema	☐ Falling
☐ Headaches	☐ High blood pressure	☐ Hepatitis A, B or C
☐ Seizures	☐ Chest pain, heart attack	☐ Sexually Transmitted Infections
☐ Hearing Loss	☐ Constipation or Diarrhea	☐ Elevated cholesterol or glucose levels
☐ Nose	☐ Difficulty controlling bowel or bladder	☐ Diabetes
☐ Throat	☐ GYN problems	☐ Memory problems
☐ Thyroid disorder	☐ Cancer/Tumors/Cysts	☐ Difficulty with sleep
☐ Allergies	☐ Back Pain	☐ Childhood Illness - specify
☐ Recent Weight Changes	☐ Other pain:	☐ Other chronic health issues:

OTHER CONCERNS

Please use the space below to share any other concerns:

PROVIDER'S COMMENTS

NAME____ DATE__________________________