Columbine Family Care Health Questionnaire

A comprehensive history is an important part of your medical record. Please complete this confidential questionnaire as accurately as possible by circling the appropriate responses and by **printing** other info as requested.

DATE ____/__/___ **Personal Patient Information**

Last name:_____ First name:_____ Middle:_____ Sex: M / F

Mailing Address _____ City_____ ST_____ Zip _____

Physical Address:_____ City:_____ ST_____ Zip_____

SS#:____/____/_____ **DOB**: ___/___/___ Main Ph#:_____ Alt Ph#: _____

Emergency Contact/Relationship:_____/_____ Phone _____

Email (for patient portal only) _____

Allergies/Medication for Allergies (state if none)

Medications

List **all** prescription/over-the-counter medicines **and** herbal remedies you take on a regular basis.

1. 3.

2. 5.

3. 6.

Patient Demographics

Please know that you have the right to refuse to supply an answer for any of the following questions below.
Please Circle the best answer below or specify:

Race: **Asian, Native Hawaiian, Other Pacific Islander, Black/African American, White, American Indian/Alaska Native, More than 1 race or Refuse to report**

Ethnicity: **Hispanic/Latino, Non Hispanic/Latino or Refuse to report**

Language: _____ **or Refuse to report**

INSURANCE

Insurance Co. Name:_____ ID # _____

Claims Address:_____ Group # _____

City: _____ State: _____ Zip: _____ Phone ( ) _____

Responsible Party Information

(If patient is under 18 years of age; parent information required here)

Name: _____ Home Phone ( )
Work Phone ( )

Address: _____

City: _____ State _____ Zip _____ SSN: _____

RELATIONSHIP TO PATIENT: Spouse

Parent Other:

Patient Employer

Name: _____ Address: _____

Phone:_____ Full time_____ Part time_____

CONSENT FOR TREATMENT

I hereby consent to such treatment procedures and patient care, which, in the judgment of my physician, may be considered necessary or advisable while a patient with ***Columbine Family Care*.**

Signed _____ **Date** _____

IMPORTANT: PLEASE READ AND SIGN BELOW

I authorize the release of any medical information necessary to process my claim. I, the undersigned agree, whether signing as agent, of patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collections I shall pay reasonable attorney fees. I understand that in an effort to provide consistent patient care to all patients ***Columbine Family Care*** reserves the right to bill for appointments missed or appointments cancelled without 24 hour notice.

I hereby assign payment directly to ***Columbine Family Care*,** BASIC BENEFITS and/or MAJOR MEDICAL (catastrophe) BENEFITS herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.
I understand that upon discharge I may request, in writing, a copy of my records. I have read, understand and signed the ***Columbine Family Care*,** Financial Policy.

Signed _____(Patient and/or Insured Party) **Date** _____