404. N Chestnut • P.O. Box 779 • Johnson, KS 67855 • 620-492-1400

Patient Information

First Name:_______________________ Last Name:_______________________

SSN:______________ DOB:______________ Phone Number:__________________

Physical Address:_______________________ P.O. Box_______________________

City:_________________ State:______________ Zip Code: _______________

Email:____

Employer: _______________________ Employer Phone Number: __________________

Employer Mailing Address: _______________ City and State ______________Zip Code______

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Race (Check all that apply): ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to specify ☐ Other Race: ______________________________

Sex assigned at birth: ☐ Female ☐ Male

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female (Male to Female) ☐ Transgender Male (Female to Male) ☐ Gender Queer

☐ Non-Binary ☐ Other ☐ Chooses not to disclose ☐ Additional gender, specify______________________

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ A sexual orientation that's not listed

☐ Not sure ☐ Chooses not to disclose ☐ Other, specify______________________________

Are you sexually active? ☐ Yes ☐ No ☐ Chooses not to disclose Date of last screening:________________

Do you have a history of unsafe sexual activity? ☐ Yes ☐ No ☐ Chooses not to disclose

Responsible Party (If Different from Patient)

First Name:_________________________ Last Name:______________________

SSN:_____________ DOB:____________ Phone Number:______________________

Physical Address:______________________________ P.O. Box__________________

City:__________________________ State:__________ Zip Code: _____________

Email:____

Patient's Spouse

First Name:______________________ Last Name:______________________

SSN:______________ DOB:______________ Phone Number:__________________

Physical Address:______________________ P.O. Box______________________

City:________________ State:______________ Zip Code: ______________

Email:____

Employer: ______________________ Employer Phone Number: __________________

Employer Mailing Address: ______________ City and State ______________Zip Code______

Other Family Members

Name__________________________Birthdate________Relationship ________

Name__________________________Birthdate________Relationship ________

Name__________________________Birthdate________Relationship ________

Name__________________________Birthdate________Relationship ________

Name__________________________Birthdate________Relationship ________

Name__________________________Birthdate________Relationship ________

Emergency Contact Information

Name__________________________Birthday________Relationship ________

Address__________________________City__________State___Zip Code______

Phone (Home)______________ (Cell)________________ (Work)______________

Insurance Information

Name of Primary Insurance____________________________ Contract #______________

Group # ______________________ Subscriber ______________________

Name of Secondary Insurance__________________________ Contract #______________

Group # ______________________ Subscriber ______________________

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

Signature: ________________________________ Date: __________________

Protected Health Information:

Authorization of Protected Health Information for discussion of care and treatment and/or payment to the person(s) specified below. This does not give the listed person(s) permission to make health care decisions for the patient. Stanton County Family Practice (SCFP) will not release Protected Health Information to anyone not listed except for when it is reasonable to assume that the patient does not object, such as when a patient brings an individual into the exam room when treatment is discussed.

☐ I hereby authorize release of my Protected Health Information for discussion of my care and treatment and/or payment to the person(s) specified below.

☐ I do not hereby authorize release of my Protected Health Information for discussion of my care and treatment and/or payment to anyone.

1. Name___________________________Relationship_________________Phone___________

2. Name___________________________Relationship_________________Phone___________

3. Name___________________________Relationship_________________Phone___________

Patient Portal Access: The patient portal provides electronic access to view parts of medical records, scheduled appointments, send questions to the medical staff, etc. The patient portal is securely maintained, and password protected.

Patient Portal Consent: ☐ Yes ☐ No

Patient's (or Guardian's) Signature Date

PATIENT CONSENT

By signing below, I consent to the following:

Confidentiality: I am aware that Information about treatment is considered confidential and will be used in a manner consistent with proper professional conduct and will only be released to outside sources under applicable state and federal law statutes and regulations or when ordered by a court.

Financial Agreement: I agree to pay SCFP for services rendered. I acknowledge that payment is due at time of service and payable upon receipt of a billing statement in accordance with regular rates and terms of the hospital financial condition of admission. This includes all co-pay amounts and deductibles. Payment agreements may be made with the billing department if accounts cannot be paid in full at the time of service. Should the account be referred to any attorney for collection, I shall pay reasonable attorney's fees and collection expense.

Insurance Billing Agreement: SCFP will file the insurance claim. The responsibility for the prompt payment of the carrier remains with the patient. It is not SCFP's policy to contact out-of-network carriers to establish what they have paid or why they have paid less than originally indicated.

I request that payment of authorized insurance benefits be made to me or on my behalf to the provider(s) of SCFP, for services rendered by the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of my Protected Health Information to be released to the Social Security Administration and Health Care Financing Administration; its intermediaries; or carriers, any information needed for insurance claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. I understand billing information relating to services rendered could be released to my insurance provider for payment of services received.

Workers Compensation Claims: Claims will be sent to the employer for processing by their compensation carrier. It will be the patient's responsibility to pay any portion of the claim that is denied or determined not to be related or if the patient fails to provide adequate information to file this claim.

Consent for Treatment (ADULT): I consent to receive any treatment or procedure deemed necessary by the professional staff at SCFP. I understand and will adhere to all the preceding statements.

Consent for Treatment (CHILD or INCAPACITATED ADULT): I hereby state that I am the parent, primary legal custodian, or joint legal custodian of the patient being presented today for treatment. I am giving consent as guardian for any treatment or procedure deemed necessary by the professional staff at SCFP. I understand and will adhere to all the preceding statements.

****I have been given the opportunity to receive a copy of the Stanton County Family Practice Notice of Privacy Practices****

Print Name of Patient: ____

Patient/Legal Guardian Signature:____________________________**Date:**____________

Assistance with completion of form provided by: ______________________________

Elizabeth Bailey, DNP • Debra L. Anderson, DNP • Sarah Castle, FNP-C

Name: ____ Date: ____________________

Chief Complaint (what is the reason for your visit today):

____

Past Medical History (please check all that apply):

Head
☐ Trauma

Eyes
☐ Blindness
☐ Cataracts
☐ Glaucoma
☐ Wear glasses/contacts

Ears
☐ Hearing aids

Nose/Sinuses
☐ Allergic Rhinitis
☐ Sinus infections

Mouth
☐ Dentures

Cardiovascular
☐ Aneurysm
☐ Angina
☐ History of blood clots
☐ Dysrhythmia
☐ High blood pressure
☐ Murmur
☐ Myocardial infarction
☐ other heart disease
____

Respiratory
☐ Asthma
☐ Bronchitis
☐ COPD
☐ Pleuritis
☐ Pneumonia

Gastrointestinal
☐ Cirrhosis
☐ GERD
☐ Gallbladder disease
☐ Heartburn
☐ Hemorrhoids
☐ Hepatitis
☐ Stomach hernia
☐ Jaundice
☐ Ulcer

Genitourinary
☐ Hernia
☐ Urinary Incontinence
☐ Kidney stones (nephrolithiasis)
☐ Other kidney disease

Musculoskeletal
☐ Arthritis
☐ Gout

Skin
☐ Dermatitis
☐ Mole(s)
☐ Psoriasis
☐ other skin conditions
____

Neurological
☐ Epilepsy
☐ Numbness/Tingling
☐ Seizures
☐ Severe headache/migraines
☐ Stroke/TIA

Psychiatric
☐ Bipolar disorder
☐ Depression
☐ Anxiety
☐ Hallucinations/Delusions
☐ Suicidal Ideation
☐ Suicide attempts

Endocrine
☐ Goiter
☐ Hyperlipidemia
☐ Hypothyroidism
☐ Thyroid disease
☐ Type I Diabetes
☐ Type II Diabetes
☐ Hormone Therapy

Heme/Onc
☐ Anemia
☐ Cancer

Infectious
☐ HIV
☐ STD
☐ Tuberculosis (dx)
☐ Tuberculosis (exposure)
☐ UTI(s)

Previous Surgeries (please list past surgeries with approximate date):

____
____
____

As you review the following list, please check any problems or conditions that you are experiencing or have experienced. If you do not have any of the problems listed in the section, please check none.

Good General Health
☐ Good general health
☐ Recent weight change
☐ Loss of Appetite
☐ Fatigue
☐ Fever/chills
Last Mammogram:____________

Ear/Nose/Mouth/Throat
☐ Difficulty swallowing
☐ Earaches
☐ Loss of hearing
☐ Loss of smell
☐ Loss of taste
☐ Painful chewing
☐ Ringing in ear
☐ Sinus infection
☐ Sores in mouth
☐ None

Eyes
☐ Blind spots
☐ Blurred vision
☐ Double vision
☐ Loss of vision
☐ Glaucoma
☐ Injury
☐ Pain
☐ None
Last eye exam:_________________

Gastrointestinal
☐ Blood in stools
☐ Increased constipation
☐ Nausea
☐ Painful bowel movements
☐ Persistent diarrhea
☐ Stomach/abdominal pain
☐ Ulcer
☐ Vomiting
☐ None
Last colonoscopy:_______________

Psychiatric
☐ Depression
☐ Anxiety
☐ Eating disorder
☐ None

Genitourinary (females only)
☐ Irregular/heavy period
☐ Vaginal discharge
# of pregnancies__________
# of miscarriages_________
Age of 1st menstrual period____
Last menstrual period_________
Last pap smear __________

Genitourinary (males only)
☐ Prostate disease
☐ Testicle pain
Last PSA: ________________

Genitourinary
☐ Kidney stones
☐ Painful/burning urination
☐ Sexual difficulty
☐ STD
☐ Urgency with urination
☐ Urine retention
☐ Blood in urine
☐ None

Heart/Lungs
☐ High blood pressure
☐ High cholesterol
☐ Irregular heart beat
☐ Pain in chest
☐ None

Muscle/Joint/Bone
☐ Difficulty walking
☐ Joint pain
☐ Joint stiffness/swelling
☐ Muscle pain/tenderness
☐ Neck pain
☐ Back pain
☐ None
Last DEXA scan: ___________

Neurological
☐ Balance trouble
☐ Loss of consciousness
☐ Difficulty speaking
☐ Headaches/migraines
☐ Injury to brain/spine
☐ Light headed/dizziness
☐ Memory loss
☐ Mental confusion
☐ Mini stroke/stroke
☐ Neuropathy
☐ Numbness/tingling
☐ Paralysis
☐ Tremors
☐ Weakness
☐ None

Pulmonary
☐ Asthma
☐ Blood in sputum
☐ Cancer
☐ Frequent cough
☐ Emphysema
☐ Pneumonia
☐ Shortness of breath
☐ None

Skin
☐ Rash/itching
☐ Hair loss
☐ Color change
☐ Acne
☐ None

Sleep
☐ Snoring
☐ Sleep walking
☐ Nightmares
Do you sleep well ☐ Yes ☐ No
Do you feel rested when you wake? ☐ Yes ☐ No
Do you nap during the day?
☐ Yes ☐ No
Do you use CPAP? ☐ Yes ☐ No

Serious Injury (please describe any serious injuries you have had):

____

____

Medications (please list any medications you are taking with dose and frequency):

Medication Name	Dose/Frequency
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Do you have any allergies? ☐ Yes ☐ No (if so please list allergen and reaction)

____

Do you smoke? ☐ Current smoker _______cigarettes/day ☐ Former smoker: quit______ years ago

Do you vape? ☐ Current vaper________ puffs/day ☐ Former vaper: quit_______ years ago

Do you consume caffeine? ☐ Yes_______ cups/day ☐ No

Do you drink alcohol? ☐ Yes_______ drinks/week ☐ No

Do you use recreational drugs? ☐ Yes ☐ No If yes, what type and frequency? ______________________

Do you feel safe? ☐ Yes ☐ No

Family History: Do you know of any blood relatives who have or had the following?

Alcoholism ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Asthma ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Arthritis ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Cancer ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Diabetes ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Depression/Anxiety ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Family History (continued)

Glaucoma ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

High Cholesterol ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

High Blood Pressure ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Stroke ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Migraines ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Thryroid ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Heart Disease ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather