Andover Family Medicine
PMH/Family-Social History/ROS
(Please FILL in the Bubbles)

Name: _____
DOB: _____

Past Medical History

Acid Reflux	O Yes	Alcohol Abuse	O Yes	Allergic Rhinitis	O Yes
Anemia	O Yes	Anxiety	O Yes	Arthritis	O Yes
Asthma	O Yes	Atrial Fibrillation	O Yes	Bipolar	O Yes
BPH	O Yes	Cancer	O Yes	CHF	O Yes
Depression	O Yes	Diabetes	O Yes	Dementia	O Yes
Glaucoma	O Yes	Hay Fever	O Yes	Heart Disease	O Yes
Hepatitis C	O Yes	High Blood Pressure	O Yes	High Cholesterol	O Yes
Irritable Bowel Synd	O Yes	Kidney Disease	O Yes	Liver Disease	O Yes
Migraine Headache	O Yes	Mitral Valve Prolapse	O Yes	Pacemaker	O Yes
Rheumatic Fever	O Yes	Seizures	O Yes	Sinus Disease	O Yes
Sleep Apnea	O Yes	STD History	O Yes	Stroke	O Yes
Thyroid Disease	O Yes	Tuberculosis	O Yes	Vertigo	O Yes

Other (please list): _____

Surgical History

Appendectomy	O Yes	Back Surgery	O Yes
C-Section	O Yes	Cardiac Catheterization	O Yes
Coronary Artery Bypass Graft	O Yes	Gall Bladder	O Yes
Hysterectomy	O Yes	Knee Replacement	O Yes
Lithotripsy	O Yes	Pacemaker, Cardiac	O Yes
Thyroidectomy	O Yes	Tonsillectomy	O Yes
Tubal ligation	O Yes	Vasectomy	O Yes

Other (please list): _____

Current Medications:

Name of Drug:	Strength of Drug:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Please list all medications including over the counter and herbal supplements

Drug Allergies/intolerances: O Yes O No

If **Yes**, Please list name of drugs and symptoms of allergy (for example: rash/nausea/vomiting):

_____

_____

Name of Pharmacy: _____ **Location:** _____

Do you prefer 30 or 90 days for maintenance prescriptions? _____

Do you use mail order pharmacy? O Yes O No Location: _____

Andover Family Medicine
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(Please FILL in the Bubbles)

Family History

Does your mother have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your father have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your paternal grand mother have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your paternal grand father have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your maternal grand mother have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your maternal grand father have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Do any of your siblings have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Do any of your children have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Number of: Brothers_____ Sisters_____ Sons_____ Daughters_____

Social History

Do you smoke? O Yes O No
If **yes**, how many packs per day? _____
If **no**, have you smoked in the past? _____
Are you exposed to smoke? O Yes O No
Do you drink caffeine? O Yes O No
Do you drink alcohol? O Yes O No
Illegal drug use history? O Yes O No
Do you exercise? O Yes O No
Are you sexually active? O Yes O No
Smoke detector in home? O Yes O No
Do you have pets? O Yes O No
Marital Status: O Single O Married O Significant Other O Divorced O Widowed
Occupation: _____

Immunization/Preventive Health (Please list month/year if known)

Date of last eye exam: ____/_____
Date of last dental exam: ____/_____
Date of last chest x-ray: ____/_____
Date of last Colonoscopy: ___/_____
(**M**)Date of last prostate exam: ___/_____
(**W**)Date of last mammogram: ___/_____
(**W**)Date of last pap smear: ___/_____
Date of last bone density/DEXA: ___/_____
(**W**)Have you had an abnormal pap smear? O Yes O No
Have you had the HPV/cervical cancer vaccine? O Yes O No
Have you had the shingles vaccine/Zostavax ? O Yes O No
Have you had a pneumonia vaccine? O Yes O No
When was you last tetanus immunization: Year: _____
Please list below any other concerns or items not addressed above

Andover Family Medicine
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(Please FILL in the Bubbles for Current Symptoms)

ALLERGY
Itchy Eyes O Yes
Nasal Congestion O Yes
Rash O Yes
Sneezing O Yes

CARDIOLOGY
Chest Pain O Yes
Palpitations O Yes
Fatigue O Yes
Leg Edema O Yes
Shortness of Air O Yes

CONSTITUTIONAL
Fever O Yes
Chills O Yes
Weight Gain O Yes
Fatigue O Yes

DERMATOLOGY
Rash O Yes
Mole O Yes
Hives O Yes
Dry or Sensitive Skin O Yes
Skin Cancer O Yes

ENDOCRINOLOGY
Excessive Thirst O Yes
Excessive Hunger O Yes
Frequent Urination O Yes
Heat Intolerance O Yes
Cold Intolerance O Yes
Hair Changes O Yes

ENT
Nasal Drainage O Yes
Sore Throat O Yes
Hoarseness O Yes
Sinus Pain O Yes
Teeth Pain O Yes
Ringing in Ears O Yes
Loss of Hearing O Yes

FEMALE REPRODUCTIVE
Irregular cycles O Yes
Vaginal Discharge O Yes
Pelvic Pain O Yes
Pain with Sex O Yes
Painful Periods O Yes
Breast Pain O Yes
Nipple Discharge O Yes

GASTROENTEROLOGY
Nausea O Yes
Vomiting O Yes
Difficulty Swallowing O Yes
Heartburn O Yes
Constipation O Yes
Diarrhea O Yes
Blood in Stool O Yes
Hemorrhoids O Yes

HEMATOLOGY/LYMPH
Swollen Glands O Yes
Fatigue O Yes
Easy Bruising O Yes
Varicose Veins O Yes

MALE REPRODUCTIVE
Erectile Dysfunction O Yes
Decreased Libido O Yes
STDs O Yes
Burning with Urination O Yes

MUSCULOSKELETAL
Joint Pain O Yes
Joint Stiffness O Yes
Joint Swelling O Yes
Back Pain O Yes
Carpal Tunnel Syndrome O Yes
Fracture O Yes
Osteoporosis O Yes

NEUROLOGY
Headache O Yes
Tingling O Yes
Numbness O Yes
Visual Changes O Yes
Dizziness O Yes
Memory Loss O Yes
Seizures O Yes
Gait Problems O Yes
Sleep Problems O Yes

OPTHALMOLOGY
Blurred Vision O Yes
Eye Redness O Yes
Eye Irritation O Yes
Eye Drainage O Yes
Eye pain O Yes

PSYCHOLOGY
Depression O Yes
Anxiety O Yes
Hallucinations O Yes
Suicidal Thoughts O Yes
Eating Disorder O Yes

RESPIRATORY
Persistent Cough O Yes
Chest Congestion O Yes
Wheezing O Yes
Shortness of Breath O Yes
Tobacco Use O Yes

UROLOGY
Painful Urination O Yes
Urinary Frequency O Yes
Blood in Urine O Yes
Incontinence O Yes
Nocturia O Yes
History of UTIs O Yes
Kidney Stones O Yes

Andover Family Medicine
Patient Information

Patient Name: _____ **Birth Date:** _____
Last First Middle Initial

Address: _____ **City/State/Zip:** _____

Sex: □ Male □ Female **SS#:** _____ **Marital Status:** _____

Race: □ Asian □ African American □ Caucasian □ Hispanic □ Other □ Prefer not to answer

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Other □ Prefer not to answer

Phone: (Please check primary contact number)

□ Home: _____ □ Cell: _____ □ Work: _____

May we leave messages? □ Yes □ No May we send text messages? □ Yes □ No

Email: _____ **Occupation:** _____

Primary provider: □ Dr. Bales □ Dr. Barclay □ Dr. Cheng □ Dr. Hall
□ Dr. Klingman □ Dr. Landers □ Dr. Meschke

Responsible Party – □ **Check if same as above**

Name: _____ Birth Date: _____
Last First Middle Initial

Address: _____ City/State/Zip: _____

Phone: _____ SS#: _____ Relationship to patient: _____

Emergency Contact

Name: _____ Relationship to patient: _____

Address: _____ Phone: _____

Insurance Information – **Please provide the receptionist with your insurance card(s) so that we can obtain a copy.**

Primary Insurance: □ Aetna □ BCBS □ Cigna □ Coventry □ Humana □ Medicare □ Tricare
□ UnitedHealthcare □ Other _____

Policy Holder's Name: _____ Birth date: _____

Policy Holder's Address: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Birth date: _____

Policy Holder's Address: _____

Referral Info

How did you hear about us? □ Family member □ Friend □ Magazine/Newspaper □ Social Media
□ Other _____

_____ _____
Patient/Legal Representative Signature Date

ANDOVER
FAMILY
MEDICINE

Assignment of Benefits:

This assignment of benefits allows Andover Family Medicine to be paid directly by my health insurance carrier, Medicare, Medicaid, Medigap or other health benefit plan for the services Andover Family Medicine provides to me, my minor child or other person entitled to health care benefits for services provided. In return for the services rendered by Andover Family Medicine, I herby irrevocably assign and transfer to Andover Family Medicine all right, title, and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting Andover Family Medicine an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of Andover Family Medicine to pursue any such right of recovery. In no event will Andover Family Medicine retain benefits in excess of the amount owed to Andover Family Medicine for the care and treatment rendered. I understand that it is my responsibility to satisfy any conditions of my insurance company. I have read and been given the opportunity to ask questions about this assignment of benefits.

Notice of Privacy Practice:

I acknowledge that I have been given the Andover Family Medicine Notice of Privacy Practices. I understand that if I have questions I may contact the privacy officer.

For Medical Card Holders Only:

This constitutes advance notice to you, the beneficiary, that if all program requirements are met by Andover Family Medicine, and payment is not made by the Kansas Medical Assistance Program (KMAP), you may be held responsible for the charges if your services are not covered by KMAP.

Kansas Immunization Registry:

I consent to inclusion of all immunization data in the Kansas Immunization Registry for the patient named below.

Patient Name: _____ Birth Date: _____

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Printed name of legal representative Relationship to patient

ANDOVER FAMILY MEDICINE

Patient Communication Authorization

This authorization gives Andover Family Medicine and its authorized representative(s) permission to disclose certain protected health information to persons I have designated.

PATIENT NAME: _____ **BIRTH DATE:** _____

CONTACT PHONE NUMBERS:

CELL ( ) _____

HOME ( ) _____

WORK ( ) _____

IF YOU ARE NOT AVAILABLE, MAY WE LEAVE A DETAILED VOICE MESSAGE?

- □ YES, PLEASE LEAVE A VOICE MESSAGE
- □ NO, DO NOT LEAVE A VOICE MESSAGE

IF WE ARE UNABLE TO REACH YOU, WHO MAY WE COMMUNICATE WITH?
(Please check all that apply)

□ COMMUNICATE WITH SELF ONLY

□ SPOUSE Name: _____ Phone: _____

- □ ANY/ALL INFORMATION
- □ APPOINTMENT INFORMATION
- □ BILLING INFORMATION
- □ MEDICATION INFORMATION
- □ PLANS OF CARE
- □ REFERRAL INFORMATION
- □ TEST RESULTS
- □ OTHER _____

□ CHILD Name: _____ Phone: _____

- □ ANY/ALL INFORMATION
- □ APPOINTMENT INFORMATION
- □ BILLING INFORMATION
- □ MEDICATION INFORMATION
- □ PLANS OF CARE
- □ REFERRAL INFORMATION
- □ TEST RESULTS
- □ OTHER _____

□ OTHER Name: _____ Phone: _____

Relationship to patient: _____

- □ ANY/ALL INFORMATION
- □ APPOINTMENT INFORMATION
- □ BILLING INFORMATION
- □ MEDICATION INFORMATION
- □ PLANS OF CARE
- □ REFERRAL INFORMATION
- □ TEST RESULTS
- □ OTHER _____

I understand this authorization will remain in effect until specifically withdrawn or changed by me or the authorized representative signing this form.

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Printed name of legal representative Relationship to patient

ANDOVER
FAMILY
MEDICINE

We are now able to send messages via text directly to your cell phone for normal lab results, refill confirmations, billing correspondence, and appointment information. Please confirm your cell phone number and let us know if you are agreeable to receiving text messages. The patient portal is also a great tool to message your physician directly for refill requests or questions about your healthcare. This may be accessed at www.andoverfamilymed.com with your assigned user name and password.

Patient Name _____

Patient Date of Birth _____

Cell Phone # (_____)_____

*If patient is a minor, cell phone number of a parent/guardian must be listed

_____**YES**, I would like to receive text messages

_____**NO**, I prefer to receive voicemail messages

_____

Signature of patient or parent/guardian Date

ANDOVER
FAMILY
MEDICINE

FINANCIAL POLICY

Effective 4/1/2014

The patient/guarantor is responsible for providing Andover Family Medicine with current, active insurance information. A copy of the insurance card will be scanned into your chart. If your insurance changes, please notify our office immediately.

Insurance co-payments are due at check-in, prior to seeing the provider. Andover Family Medicine will submit claims to your primary and secondary insurance as indicated. Once the insurance has processed, an account statement will be mailed to the guarantor of the account for any non-covered services, deductibles, or co-insurance.

Payment is due in full within 60 days of the first statement. Patients who fail to pay the account balance within 60 days will become inactive and unable to schedule appointments or receive refills until paid in full. Patients who fail to pay within 90 days of the first statement will be sent to a collection agency.

In certain circumstances, Andover Family Medicine may contact your insurance in advance to inquire about coverage for special procedures or tests. If it is determined that the service is not covered or will be applied to your deductible, we may require payment in advance.

Andover Family Medicine accepts personal checks (payable to AFM), Visa, MasterCard and Discover credit cards.

I have read and understand the Financial Policy of Andover Family Medicine.

_____ _____

Patient Name Date of Birth

_____ _____

Patient / Guarantor Signature Date

ANDOVER FAMILY MEDICINE

Medical Record Release Authorization

Patient name:_____ Birth Date: _____

Maiden name: _____ Social Security #:_____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell: _____ Work: _____

I hereby authorize records **FROM**:

Facility or Physician:_____

Address:_____

City/State/Zip:_____

Phone:_____ Fax:_____

To be released **TO**:

Andover Family Medicine

2117 N. Keystone Circle

Andover, KS 67002

Phone (316) 733-5120 Fax (316) 733-1280

Purpose of the request:

_____ Transfer or Continuity of Care _____ Self/Personal Copy _____ Insurance _____ Litigation

_____ Disability _____ Work Comp _____ Other:_____

Records requested:

What specific records may be disclosed: Date Range: _____ to _____

_____ Physician Office Notes
_____ Radiology/X-Ray/MRI Reports
_____ Operative/Procedure Reports
_____ Lab/Pathology Reports
_____ Cardiology/EKG Reports
_____ ER Reports
_____ Immunizations
_____ Entire Record

Expiration

This authorization will expire one year from the date below unless I specify an earlier expiration date: _____

Statement of Understanding

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I am the patient listed or I am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient/Legal Representative: _____ Date: _____

Printed Name: _____ Relationship: _____

We reserve the right to charge the medical record state fee structure as set forth in the state statute.