

**Andover Family Medicine
Patient Information**

Legal Name: _____ **Preferred Name:** _____
Last First Middle Initial

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

Birth Date: _____ **SS#:** _____ **Marital Status:** _____

Sex: Male Female Prefer not to answer Additional Information/Category _____

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. Cheng Dr. Hall
 Dr. Landers Dr. Meschke Dr. Worley

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

Name: _____
DOB: _____
Date: _____

Past Medical History

- | | | | | | |
|----------------------|---------------------------|-----------------------|---------------------------|-------------------|---------------------------|
| Acid Reflux | <input type="radio"/> Yes | Alcohol Abuse | <input type="radio"/> Yes | Allergic Rhinitis | <input type="radio"/> Yes |
| Anemia | <input type="radio"/> Yes | Anxiety | <input type="radio"/> Yes | Arthritis | <input type="radio"/> Yes |
| Asthma | <input type="radio"/> Yes | Atrial Fibrillation | <input type="radio"/> Yes | Bipolar | <input type="radio"/> Yes |
| BPH | <input type="radio"/> Yes | Cancer | <input type="radio"/> Yes | CHF | <input type="radio"/> Yes |
| Depression | <input type="radio"/> Yes | Diabetes | <input type="radio"/> Yes | Dementia | <input type="radio"/> Yes |
| Glaucoma | <input type="radio"/> Yes | Hay Fever | <input type="radio"/> Yes | Heart Disease | <input type="radio"/> Yes |
| Hepatitis C | <input type="radio"/> Yes | High Blood Pressure | <input type="radio"/> Yes | High Cholesterol | <input type="radio"/> Yes |
| Irritable Bowel Synd | <input type="radio"/> Yes | Kidney Disease | <input type="radio"/> Yes | Liver Disease | <input type="radio"/> Yes |
| Migraine Headache | <input type="radio"/> Yes | Mitral Valve Prolapse | <input type="radio"/> Yes | Pacemaker | <input type="radio"/> Yes |
| Rheumatic Fever | <input type="radio"/> Yes | Seizures | <input type="radio"/> Yes | Sinus Disease | <input type="radio"/> Yes |
| Sleep Apnea | <input type="radio"/> Yes | STD History | <input type="radio"/> Yes | Stroke | <input type="radio"/> Yes |
| Thyroid Disease | <input type="radio"/> Yes | Tuberculosis | <input type="radio"/> Yes | Vertigo | <input type="radio"/> Yes |
- Other (please list): _____

Surgical History

- | | | | |
|------------------------------|---------------------------|-------------------------|---------------------------|
| Appendectomy | <input type="radio"/> Yes | Back Surgery | <input type="radio"/> Yes |
| C-Section | <input type="radio"/> Yes | Cardiac Catheterization | <input type="radio"/> Yes |
| Coronary Artery Bypass Graft | <input type="radio"/> Yes | Gall Bladder | <input type="radio"/> Yes |
| Hysterectomy | <input type="radio"/> Yes | Knee Replacement | <input type="radio"/> Yes |
| Lithotripsy | <input type="radio"/> Yes | Pacemaker, Cardiac | <input type="radio"/> Yes |
| Thyroidectomy | <input type="radio"/> Yes | Tonsillectomy | <input type="radio"/> Yes |
| Tubal ligation | <input type="radio"/> Yes | Vasectomy | <input type="radio"/> 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: Yes 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? Yes No Location: _____

Family History

Does your mother have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Does your father have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Does your paternal grand mother have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Does your paternal grand father have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Does your maternal grand mother have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Does your maternal grand father have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Do any of your siblings have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Do any of your children have any of the following?

- Diabetes High Blood Pressure Heart Disease Stroke Mental Illness Cancer

Number of: Brothers _____ **Sisters** _____ **Sons** _____ **Daughters** _____

Social History

Do you smoke/vape/chew tobacco? Yes No

If **yes**, how many packs/cans per day? _____

If **no**, have you used tobacco in the past and what age did you quit? _____

Are you exposed to smoke? Yes No

Do you drink caffeine? Yes No

Do you drink alcohol? Yes No

Illicit drug use? Yes No

Do you exercise? Yes No

Smoke detector in home? Yes No

Do you have pets? Yes No

Are you sexually active? Yes No If **yes**, what is your sexual orientation: Straight Gay/Lesbian Bisexual

Marital Status: Single Married Significant Other Divorced Widowed

Occupation: _____

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

Date of last eye exam: ____/____

Date of last chest x-ray: ____/____

Date of last dental exam: ____/____

Date of last Colonoscopy: ____/____

(W)Date of last mammogram: ____/____

(M)Date of last prostate exam or PSA: ____/____

(W)Date of last pap smear: ____/____

Date of last bone density/DEXA: ____/____

(W)Have you had an abnormal pap smear? Yes No

Have you had the COVID-19 vaccine? Yes No

Have you had the shingles vaccine? Yes No

Have you had a pneumonia vaccine? Yes No

When was your last tetanus immunization? Year: _____

Please list below any other concerns or items not addressed above:

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

Name: _____
DOB: _____
Date: _____

ALLERGY

- Itchy Eyes Yes
- Nasal Congestion Yes
- Rash Yes
- Sneezing Yes

CARDIOLOGY

- Chest Pain Yes
- Palpitations Yes
- Fatigue Yes
- Leg Edema Yes
- Shortness of Air Yes

CONSTITUTIONAL

- Fever Yes
- Chills Yes
- Weight Gain Yes
- Fatigue Yes

DERMATOLOGY

- Rash Yes
- Mole Yes
- Hives Yes
- Dry or Sensitive Skin Yes
- Skin Cancer Yes

ENDOCRINOLOGY

- Excessive Thirst Yes
- Excessive Hunger Yes
- Frequent Urination Yes
- Heat Intolerance Yes
- Cold Intolerance Yes
- Hair Changes Yes

ENT

- Nasal Drainage Yes
- Sore Throat Yes
- Hoarseness Yes
- Sinus Pain Yes
- Teeth Pain Yes
- Ringling in Ears Yes
- Loss of Hearing Yes

FEMALE REPRODUCTIVE

- Irregular cycles Yes
- Vaginal Discharge Yes
- Pelvic Pain Yes
- Pain with Sex Yes
- Painful Periods Yes
- Breast Pain Yes
- Nipple Discharge Yes

GASTROENTEROLOGY

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

HEMATOLOGY/LYMPH

- Swollen Glands Yes
- Fatigue Yes
- Easy Bruising Yes
- Varicose Veins Yes

MALE REPRODUCTIVE

- Erectile Dysfunction Yes
- Decreased Libido Yes
- STDs Yes
- Burning with Urination Yes

MUSCULOSKELETAL

- Joint Pain Yes
- Joint Stiffness Yes
- Joint Swelling Yes
- Back Pain Yes
- Carpal Tunnel Syndrome Yes
- Fracture Yes
- Osteoporosis Yes

NEUROLOGY

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

OPHTHALMOLOGY

- Blurred Vision Yes
- Eye Redness Yes
- Eye Irritation Yes
- Eye Drainage Yes
- Eye pain Yes

PSYCHOLOGY

- Depression Yes
- Anxiety Yes
- Hallucinations Yes
- Suicidal Thoughts Yes
- Eating Disorder Yes

RESPIRATORY

- Persistent Cough Yes
- Chest Congestion Yes
- Wheezing Yes
- Shortness of Breath Yes
- Tobacco Use Yes

UROLOGY

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



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 hereby 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:

Kansas state law (KSA 65-2886a) mandates that vaccine providers, including physician offices, report administered immunizations to the statewide registry. This universal reporting requirement ensures accurate, centralized immunization records for children and adults, which can be shared with authorized providers for public health purposes. To opt out, patients or guardians must submit a written request to the Kansas Department of Health and Environment (KDHE), Attn: Kansas Immunization Registry, 1000 SW Jackson, Suite 210, Topeka, KS 66612.

Patient Name: _____ Birth Date: _____

Patient/Legal Representative Signature

Date

Printed name of legal representative

Relationship to patient



FINANCIAL POLICY

Updated 5/1/2023

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.

Patients who participate in a health sharing program or who are known to have a high deductible will be asked to make a down payment at check-in. You may also be asked for a deposit if you have a large balance on your account or have a history of non-payment.

Andover Family Medicine accepts cash, personal checks, and credit cards.

My signature below indicates that I have read, understand, and agree to the Andover Family Medicine Financial Policy.

Printed Patient Name

Date of Birth

Patient / Guarantor Signature

Date



Text Message Authorization

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 note that you cannot reply to our office via text message.** 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 phone calls/voice messages

Signature of patient or parent/guardian

Date



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

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.