Longmont Integrative Family Practice, PLLC

2130 Mountain View Ave, Suite 203
Longmont, CO 80501
Phone 303-776-8847 Fax 303-776-8897

Patient Information

Please complete prior to your appointment and bring with you to your appointment Today's Date_____

Patient Name First_____ M.I._____ Last_____

Birthdate_____Age_____SS#_____-_____-_____Nickname_____Sex: M F

Phone Home (_____)_____ Work (_____)_____ Cell (_____)_____

Home Address_____

City_____State_____Zip_____

Email _____

Employer_____

Address_____City_____State_____Zip_____

If Patient is a minor: Parent/Guardian Name_____Relationship_____

If married , please provide spouse's information :

Name_____Birthdate_____

Employer_____Phone (_____)_____

Emergency Contact Name_____Relation_____

Phone(_____)_____ Work Phone(_____)_____

PREFERRED PHARMACY			
	Name of Pharmacy	Address	Phone

BILLING AND INSURANCE

Person responsible for bill _____

Does the responsible party have insurance?_____Relationship to Subscriber: Self Spouse Child Other_____

Primary Insurance_____
Subscriber Name_____
Subscriber Birthdate_____
Subscriber SSN_____-_____-_____
Member ID_____Group No_____

Secondary Insurance_____
Subscriber Name_____
Subscriber Birthdate_____
Subscriber SSN_____-_____-_____
Member ID_____Group No_____

Patient/Guardian Signature_____Date _____

Printed Name (if different from patient)_____Relation_____

Longmont Integrative Family Practice
HEALTH QUESTIONAIRE

This comprehensive health questionnaire is designed to be a window into your health and well-being. Please take your time and answer all questions as thoroughly as possible. Your ability to complete the questionnaire helps us assess your personal healthcare needs so we can be the most help to you.

Although it may be tempting to have a spouse or partner fill this out for you, it is important to fill this form out YOURSELF, as no one knows you as well as you do!

Bring this form with you to your first appointment. Please make every effort to have it filled out completely prior to your appointment time. It should take about 20 minutes to complete the questionnaire.

What issue(s) bring you to see Dr. Weeman?_____

_____

_____

_____

How did you learn about Longmont Integrative Family Practice? With your permission, we would like to thank any individual that recommended us to you_____

_____

Medical History/ Family History

ABOUT YOU: Circle any condition YOU have or have been treated for:

Asthma Arthritis COPD Emphysema Cancer: _____ Congestive Heart Failure
Depression Diabetes Epilepsy Heart Attack Heart Disease High Blood Pressure High Cholesterol
Hormone Imbalance Neurologic Disorder Sleep Apnea Thyroid Disorder Eczema
Other_____

_____

ABOUT YOUR FAMILY:	Age	If deceased, age at death	Medical Conditions
Father	_____	_____	_____
Mother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____

Other significant family diseases?_____

_____

_____

Surgery/Hospitalization	Year	Surgery/Hospitalization	Year

Allergies to Medication ***Check if NO KNOWN ALLERGIES*** ◯

Medication	Reaction	Medication	Reaction

Allergies to Food, Chemicals, Environmental (pollen, grass, dust, etc)

Allergen	Reaction to allergen (eg. Rash, shortness of breath)

Current Prescription Medications

Medication Name	Mg or strength	Times a day	What do you take this for?	How long have you taken?

Supplements or Herbal Remedies (Include over-the-counter, home-made, natural aids)

Supplement	Mg or strength	Times a day	What do you take this for?	How long have you taken?

Social History

Current Occupation_____
Previous Occupations_____

Education: Highest level achieved ____Grade school ____High school ____College ____Graduate school

Languages spoken_____
Travel: Foreign countries visited_____
In the last 12 months_____

Recreation/Hobbies_____
Exercise: Type_____Frequency_____
Religion/Beliefs_____

Sexual Orientation(circle one) heterosexual gay/lesbian bisexual transsexual abstaining
Ethnicity_____
Marital Status ◯ Single ◯ Married ◯ Divorced ◯Widowed

Names/ages of children_____
_____
_____

Living arrangement: Who do you currently live with?_____
_____
_____

Pets at home? What kind?_____

HABITS

Do you smoke? ___No, never smoked.
___Yes, I smoke_____packs of cigarettes per day for_____years
___ No, not currently. I quit_____years ago. I smoked_____packs a day for_____years
___ Yes, I smoke cigars or a pipe,_____a day for_____years

Do you drink alcohol? ___No, never
___Yes, How many drinks a ____day ____week _____month _____year

Do you use street/illicit drugs? ____No, never
____Not anymore. I used to use_____
____Yes, List: _____

Caffeine: Do you drink coffee, soda, tea, energy drinks? _____
How much and what kind?_____

DIET

Diet: ____Regular_____Vegetarian ____Gluten-free ____High Protein ____Low Protein ____Low Fat ____Vegan

Other_____

STRESS

Circle your level of stress 0 1 2 3 4 5 6 7 8 9 10
None Average Severe

What bothers you most? _____
_____
_____

Patient Name_____4/7

Review of Systems

Do you have any of the following? If the symptom occurs rarely or a long time ago, do not check it.
CHECK ALL SYMPTOMS THAT ARE CURRENT OR RECENT.

General	____weight loss (unintentional)	____weight gain	____weakness
	____fatigue	____unexplained fever, chills	____night sweats
	____loss of appetite	____excessive appetite	____sleep problems
Head	____headache	____loss of consciousness	____balance problems
	____head injury		
Eyes	____blurred vision	____loss of vision	____redness
	____irritated eyes	____eye pain	____glaucoma
	____double vision	____sensitivity to light	Last eye exam date_____
Ears	____ringing	____ear pain	____ear discharge
	____hearing loss		
Nose	____sinusitis	____loss of smell	____abnormal smell
	____congestion	____allergies	____bloody nose
	____post nasal drip		
Mouth	____cold sores	____bleeding gums	____sore tongue
	____dental problems	____jaw pain	____grinding teeth
Throat	____sore throat	____throat pain	____difficulty swallowing
	____change in voice	____hoarseness	
Neck	____neck pain	____neck lumps	____neck injury
	____loss of motion	____thyroid problems	
Lungs	____wet cough	____dry cough	____bloody cough
	____wheezing	____shortness of breath	____emphysema
	____snoring	____bronchitis	____stopping breathing at night
Heart	____chest pain	____palpitations	____heart skipping beats
	____swelling legs, feet	____heart murmur	____high blood pressure
	____history of scarlet fever		
Blood Vessels	____painful or swollen veins	____leg cramps/pain	____cold or blue fingers/toes
	____leg/feet ulcers		
Abdominal	____abdominal pain	____nausea/vomiting	____vomiting blood
	____burping/belching	____excessive passing gas	____heartburn
	____difficulty swallowing	____constipation	____diarrhea
	____change in bowels	____rectal pain	____bloody/ black stools
	____abdominal bloating	____cramps	____rectal bleeding
	____change in appetite		
Urine/Bladder	____blood in urine	____painful urination	____urgency to urinate
	____frequent urination	____urination at night	____hesitancy to urinate
	____dribbling/ incontinence	____slow stream	____loss of urine with cough/sneeze
Musculoskeletal	____muscle pain	____muscle cramps	____muscle weakness
	____joint pain	____joint swelling	____back pain
	____muscle weakness		
Nerves/Brain	____seizures	____dizziness/room spinning	____numbness or tingling
	____memory issues	____loss of consciousness	____shaking/tremors

Patient Name_____

Review of Systems, continued

Glandular
____weight gain/loss ____ night sweats ____excessive thirst
____changes in hair ____excessive sweating ____heat or cold intolerance
____fatigue ____dry skin

Blood
____easy bruising, bleeding ____history of anemia ____history of blood transfusions
____lymph node swelling

Skin
____rashes ____changes in moles ____skin growths/tags
____varicose veins ____skin changes ____nail problems
____sores that won't heal ____dry skin

Mood
____sadness ____nervousness ____forgetfulness
____loss of interest in hobbies ____memory loss ____excessive anger
____loss of enjoyment in activities ____feeling worthless ____feeling hopeless
____panic attacks ____difficulty making decisions ____excessive hand washing
____feeling others are after you ____hearing voices ____suicidal thoughts
____excessive alcohol or drug use ____sexual problems ____relationship problems
____self mutiliation ____eating disorder ____mood swings

Other symptoms not described above

_____
_____
_____
_____

FOR WOMEN How many times have you been pregnant? _____ Miscarriages?_____ Abortions?_____
How many children have you delivered?_____ How many children are alive?_____
Age that menstrual periods started _____ First Day of Last Period_____
Periods are regular?_____How often?_____
Birth Control method_____

____excessive flow ____irregular periods ____painful period, cramps
____pain with intercourse ____bleeding with intercourse ____pelvic pain
____vaginal discharge ____vaginal dryness ____vaginal odor
____sexual problems ____breast lumps ____nipple discharge
____breast pain ____sexually transmitted disease

FOR MEN
____erection problems ____ejaculation problems ____testicular pain
____discharge from penis ____testicle lump ____change in size of testicle
____urination problems ____sexually transmitted disease

How many times to you get up to urinate at night?_____
Birth Control method_____

Preventative Medicine History

Please indicate the date of the last :

	Date	
Mammogram(women)	_____	____Never
Pap smear(women)	_____	____Never
Bone Density Scan	_____	____Never
Abdominal Ultrasound	_____	____Never
PSA (men)	_____	____Never
TB Test	_____	____Never
Electrocardiogram	_____	____Never
Colonoscopy	_____	____Never
Cardiac Stress Test	_____	____Never
Pulmonary Function	_____	____Never

Vaccines

Tetanus	_____	____Never
Pneumococcal	_____	____Never
Hepatitis A	_____	____Never
Hepatitis B	_____	____Never
Shingles(Chicken Pox)	_____	____Never
Influenza(Flu)	_____	____Never
HPV (Gardasil)	_____	____Never

Other vaccines you have received_____

_____

For Children: Are immunizations up to date? YES NO Please provide a copy of current immunizations.

Is there anything that Dr. Weeman should know about your preference for immunizations?_____

_____

Cholesterol Test	_____	____Never
Dental Cleaning	_____	____Never
Eye Exam	_____	____Never
Gynecologic Exam	_____	____Never

Medical-Legal

Do you have a living will? _____ Do you have a Durable Medical Power of Attorney?_____

Patient (Guardian) Signature_____ Date_____7/7

Longmont Integrative Family Practice, PLLC
Patient Financial Policy

The following is a statement of our financial policy. Please read and sign. If you have any questions, please do not hesitate to ask.
All new patients must complete the Patient Registration packet as well as the Financial Policy before being seen as a patient.

Co-Pays and/or deductibles are due in full at the time of service.
For your convenience, we accept Visa, MasterCard, personal checks and, of course, cash.
Payment Plans are available upon approval by the business office.
Failure to show for an appointment is subject to a **$35 NO SHOW FEE.** Every attempt should be made to contact the office in the event an appointment will be missed.
Return check fee for insufficient funds is $35.00.

Regarding Insurance
Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will bill your insurance plan on your behalf, as long as you provide us with the correct information. Please be aware that some, or perhaps all, of the services may be deemed non-covered services and/or not considered medically necessary by your insurance plan. You, as the patient, is ultimately responsible for payment of all services provided by this office. In the event that your insurance coverage changes to a plan we do not participate in, your insurance may not cover submitted charges. While payment is your responsibility, we will assist you in negotiating with your insurance company for any disputed claims. Our business department is available to discuss any questions you may have regarding your insurance coverage or your financial account.
If you have a secondary insurance, we will bill for you, as a courtesy, as long as you have provided us with the appropriate information. If you bill any insurance yourself, please do so promptly so that you will receive reimbursement before your account is considered delinquent.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our service area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
MEDICALLY NECESSARY CARE
We will only provide you with a service if we consider it medically necessary. If your insurance company determines that a service we have rendered to you is unnecessary you will still be responsible for the bill.
CREDIT POLICY
Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days, and may be subject to collection action and interest charged at 18% per annum.
COLLECTIONS
On occasion it may be necessary to arrange a payment plan. If financial hardship arises please contact our business office as soon as possible. If an account becomes excessively overdue, necessary action may be taken to recover the account balance due and you will be discharged from our medical care.

FINANCIAL AGREEMENT
I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 60 days after receipt of the bill, a delinquent charge or interest at the maximum rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any outstanding debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. I consent to be contacted by regular mail, email or telephone, including cell phone, regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.

MEDICARE and/or MEDICAID CERTIFICATION
I certify that the information given by me in applying for payment under Medicare/Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

PREAUTHORIZATION REQUIREMENTS
I understand that it is my sole responsibility to verify all preauthorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's charges. I also understand that my insurance may require an office visit referral to be seen. It is my responsibility to acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be responsible for the charges incurred during the visit.

ASSIGNMENT FOR DIRECT PAYMENT
I authorize and direct any payment for an insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice.
I understand that I am financially responsible to the practice for charges not covered or paid pursuant to this authorization.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that Longmont Integrative Family Practice has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also available on www.drweeman.com.
By choosing one of the following, I acknowledge: ___**I have been offered or accepted a copy of the Notice of Privacy Practices**
___I decline a copy of the Notices of Privacy Practices

I have fully read and understand the Longmont Integrative Family Practice Financial Policy and agree to the terms of this agreement.

Signature of Patient/Responsible Party_____ Date_____/_____/_____

LONGMONT INTEGRATIVE FAMILY PRACTICE, PLLC

GLENDA C. WEEMAN DO
PHYSICIAN & SURGEON
BOARD-CERTIFIED ACOFP

Permission for Communication

Longmont Integrative Family Practice would like to notify you based on your preferred method of contact. We respect your privacy. Contact may consist of automated reminder calls, lab or test results or return messages. No lab or test results will verbally be left with another person unless you give us permission.

PREFERRED METHOD OF CONTACT:

The following number is where I would like to be contacted/messages to be left:

(_____) _____-_____

YOU MAY DISCUSS MY HEALTHCARE WITH THE FOLLOWING:

_____ _____
Print Name Relationship to Patient

_____ _____
Print Name Relationship to Patient

You may discuss the following:

_____ Any and All Health Information
_____ Appointment Time Only
_____ Test Results Only

Patient Signature_____

Patient Name_____ Date_____

Updated Aug 12, 2013