Juniper Family Medicine
735 White Avenue, Grand Junction, CO 81501
Phone 970-248-5880 Fax 970-241-1112

New Patient Application

Date:_________________ Have you been seen at Juniper Family Medicine before? Yes No
Please Circle Preferred Provider: Laura Campbell Kate Pierce
Name: ____ Date of Birth:___________________________
Address:_______________________________________City:________________________Zip:_________________
Phone Number:________________________________Work Phone:_____________________________________
Cell Number: __________________________________Which number do you prefer:________________________
Sex:_________________ Marital Status: Single Married Divorced Widowed Separated
Social Security Number:___________________________Email:____
Race:_________________________Ethnicity:___________________________Language(s):___________________

Preferred pharmacy:________________________________Address:____
Mail order pharmacy:_______________________________Phone:____

Employer:____Occupation:______________________________
Emergency Contact:______________________________________Relationship:____________________________
Phone Number:__________________Work Number:______________________Cell Number: _________________

Responsible Party:____Date of Birth:_________________________
Relationship:__________________________________Social Security Number:_____________________________
Address:_______________________________________City:________________________Zip:_________________
Phone Number:________________________________Monument Health Y/N
Primary Insurance:____ Phone:_________________________________
Primary Insured Name:_____________________________________ Birthdate:______________________________
Policy:____ Group:_________________________________
Secondary Insurance:_______________________________________ Phone:_________________________________
Secondary Insured Name:____________________________________ Birthdate:______________________________
Policy:____ Group:_________________________________

Please note that our JFM providers will not provide chronic pain medication such as prescription opiates. If you are seeing a specialist for your pain please list:
Specialist Name:_______________________________________Medical issue/s being treated: _____________
____

Current Pain Medications:

Medication	Dose	How often do you take?

All other Current Medications:

Medication	Dose	How often do you take?

Past Medical History

Problem:	**Y/N**	**When?**	**Problem:**	**Y/N**	**When?**
ADD or ADHD			GERD		
Allergies			GI problems		
Anemia			Gout		
Anesthesia problems			Headaches/Migraine		
Anxiety			Heart problems		
Arthritis			Hepatitis		
Asthma			High Blood Pressure		
Bed Wetting			High Cholesterol		
Bladder problem			Hypothyroidism		
Blood diseases			Hyperthyroidism		
Breast Cancer			Kidney problem		
Breast Problem			Kidney Stones		
Cancer			Liver Disease		
Chicken Pox			Lung Disease		
Chronic Pain			Muscle/Joint/Bone problem		
Congenital anomalies			Osteoarthritis		
Constipation			Osteoporosis		
COPD			Psychiatric illness		
Coronary Artery Disease			Pulmonary Embolism/blood clot		
Depression			Rheumatoid Arthritis		
Developmental/Behavioral problems			Scoliosis		
Diabetes			Seizure/Epilepsy		
Diverticulitis			Serious injuries		
Ear/Hearing problems			Stroke		
Eczema/Hives/Skin problem			Tuberculosis		
Endometriosis			Frequent Urinary Tract Infections		
Fibromyalgia			Varicose Veins		

Allergies to Medications:

Medication	Reaction

Past Surgical History:

Procedure	Date	Surgeon/Hospital

Family History: *Please specify if paternal (father's side) or maternal (mother's side) grandmother/grandfather*

Relative:	Problem:	Died at Age?
Paternal Grandfather Paternal Grandmother		
Maternal Grandfather Maternal Grandmother		
Father		
Mother		
Sibling		
Children		
Other		

Health Maintenance (Females only)

Are you still getting pap smears? Y/N When was your last one?______________________________________

Have you ever have an abnormal one? Y/N If so, what was done?____

Are you getting mammograms? Y/N Have you ever had an abnormal one? Y/N

If so, what was done about it?____

Have you had a bone density screening done? Y/N When and what was the result?_________________________

Have you ever had a colonoscopy? Y/N When and what was the result?__________________________

Health Maintenance (Males only)

Have you had a bone density screening done? Y/N When and what was the result?__________________________

Have you had a colonoscopy? Y/N When and what was the result?__________________________

Have you ever had a PSA (prostate) screening done? Y/N When and what was the result?__________________

Social History: (We recognize that these questions are sensitive. However, completing this section will help us better care for you.)

How far did you go in school:________________________Do you have any children/how many:_____________________

What is your sexual orientation:________________________________Are you currently sexually active:______________

Are you using any type of birth control:__________________________Are you safe in current relationship:____________

Do you have difficulty doing any of the following?

Concentrating, remembering or making decisions? Y/N Doing errands alone? Y/N

Dressing or bathing? Y/ N Driving at night? Y/N Walking or climbing stairs? Y/N

If you are a dependent, who is your primary caregiver?____

Is it difficult to pay heat, water, or electricity bills? Y/N Do you have a consistent place to live? Y/N

Do you go hungry because you do not have enough food? Y/N Do you feel safe in your current living situation? Y/N

Do you have problems with transportation? Y/N

How often do you exercise? None Occasionally Moderate Heavy

Stress level: Low Medium High

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several	More than half	Nearly everyday
Little interest or pleasure in doing things?	0	1	2	3
Feeling down depressed or hopeless?	0	1	2	3

How often do you drink alcohol and how many drinks at a time?________

Male Patients ONLY: When was the last time you had 5 or more drinks in one day?

Never More than 3 months ago 1-3 months ago 8-29 days ago In the past week

Female Patients ONLY: When was the last time you had 4 or more drinks in one day?

Never More than 3 months ago 1-3 months ago 8-29 days ago In the past week

Do you currently use tobacco products? Y/N if so, how much?____
Smoking: Y/N Chewing tobacco: Y/N
If you previously used tobacco, how much did you use and when did you quit?_________________________________
Do you use any other recreational drugs?____
Caffeine intake: None 1-2/day 3-4/day 5+/day
If you have guns in your home are they locked up? (This information is not shared with anyone-it is a safety question)____
Do you use your seatbelt on a routine basis? Yes No Do you regularly use sunscreen? Yes No
Do you have carbon monoxide and smoke detectors in your home?____
Do you have an Advanced Directive? Yes No If yes, please bring copy for your chart

Previous Doctor:____
Reason for leaving:____

Who referred you to JFM?____

Do you have others living in your home that come to JFM?__________________ __________________________

____________________________ ___________________________ _____________________________

What are you needing to be seen for?____

Your Medical Records will be retrieved from your previous provider once you have been accept as a patient. The physician will decide what information they will request from the previous treating provider.

By signing below, you agree that the above information is true and correct. You authorize Juniper Family Medicine PLLC. to leave a voicemail on the phone number (s) above unless otherwise noted. Should there be any missing information: Juniper may refuse service.. By signing this, I also acknowledge receipt of Juniper Family Medicine, PLLC HIPAA Privacy Act Policy. This indicates we participate with Colorado Prescription Monitoring Program and Quality Health Network which is a centralized data base for healthcare professional and authorize Rx prescription history consent. I hereby give a lifetime authorization for payment for insurance benefits to be made directly to Juniper Family Medicine. I understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default: I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

______________________________________ ______________________________
Signature Date

Name of Patient:____ Date of Birth:____________________________

Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

____ ________________________________

Patient Signature **Date**

Authorization for Protected Communication

I, _______________________________________, prefer to be contacted in the following manner

- ☐ Patient portal – Preferred E-mail Address:____
- ☐ Telephone – Preferred Phone Number:____
- ☐ Written Communication – Home Address:____
- ☐ Other:____

Access to Information

Juniper Family Medicine may share or access medical information about me from/with the following person(s):

Name	Relationship	Telephone #	Is this person also an emergency contact? Yes/No

Appointment Cancellation/No Show Policy Agreement

If you wish to cancel your appointment it must be done 24 hours in advance of scheduled time. If you fail to make your appointment and do not call to cancel it or you no show, you will be charged $25. If you No Show the second visit it will be $50 and on the third visit you will be dismissed from the practice. This will not be paid by your Insurance, and you will be fully responsible to pay it. If you No Show your 1st new patient visit you will NOT be rescheduled.

____ ________________________________

Patient Signature **Date**