# New Patient Application

*Juniper Family Medicine, 735 White Ave, Grand Junction, CO 81501*

*Phone 970-248-5880* *Fax 970-241-1112*

***We ask that vaccines are a part of your family's healthcare****

**Date:_____ Have you been seen at JFM before? Yes No**

**Please indicate if there is a provider preference: Campbell Pierce**

Name:_____DOB:_____

Address:_____City/State:_____Zip_____

Preferred Phone #:_____Alternative Phone #:_____

Sex:_____ Partner Status: Married Divorced Widowed Separated

Social Security Number:_____ Email:_____

Race:_____Ethnicity:_____Language(s):_____

Preferred Local Pharmacy:_____Address:_____

Mail Order Pharmacy:_____

Employer:_____Occupation:_____

Emergency Contact:_____Relationship:_____

Preferred Phone #:_____Alternative Phone #:_____

Responsible Party:_____DOB:_____

Relationship:_____SSN#:_____

Address, if different than above:_____

Phone #:_____ Monument Health? Yes No

Primary Insurance: _____Phone:_____

Primary Insured Name, if different than Responsible Party:_____

DOB:_____ Policy #_____ Group #_____

Secondary Insurance:_____Phone:_____

Secondary Insured Name, if different than above:_____

DOB:_____ Policy #:_____Group #:_____

***Please bring insurance card, or provide a copy of both sides, when submitting application***

JFM Providers do not provide pain management or long-term narcotics. If you are seeing a pain specialist, please provide the following: Provider Name: _____

Condition being treated:_____

**Current Prescription PAIN medications:**

| Medication | Dose | How often? |
|---|---|---|
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**All other current prescriptions:**

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|---|---|---|
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**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 | | |
| Bone Problem | | | Hypothyroidism | | |
| Bladder Problem | | | Hyperthyroidism | | |
| Blood diseases | | | Kidney Problem | | |
| Breast Cancer | | | Kidney Stones | | |
| Breast Problem | | | Liver Disease | | |
| Cancer | | | Lung Disease | | |
| Chicken Pox | | | Muscle Problem | | |
| Chronic Pain | | | Multiple Sclerosis | | |
| Congenital Anomalies | | | Osteoporosis | | |
| Constipation | | | Psychiatric Illness | | |
| COPD | | | Blood clots | | |
| Coronary Artery Disease | | | Rheumatoid Arthritis | | |
| Depression | | | Scoliosis | | |
| Developmental/Behavioral Problems | | | Seizures/Epilepsy | | |
| Diabetes | | | Serious Injuries | | |
| Diverticulitis | | | Stroke | | |
| Ear/Hearing Problems | | | Tuberculosis | | |
| Eczema/Hives/Skin Problem | | | Frequent Urinary Tract Infections | | |
| Endometriosis | | | Varicose Veins | | |
| Fibromyalgia | | | | | |

**Allergies to Medications:**

| Medication | Reaction |
|---|---|
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**Past Surgeries:**

| Procedure | Date | Surgeon/Location |
|---|---|---|
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**Family History:** *Paternal=Father's Side, Maternal=Mother's Side*

| **Relative** | **Problem** | **Died at Age?** |
|---|---|---|
| Mother | | |
| Father | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |
| Sibling | | |
| Children | | |
| Other | | |

**Health Maintenance for Females. Please provide dates.**

Last PAP? _____ Any abnormal? **Y N** Treatment? _____

Last Mammogram? _____ Any abnormal? **Y N** Treatment? _____

Last Bone Density? _____ Abnormal? **Y N** Treatment? _____

Last Colon Cancer Screening? _____ Please circle type: Colonoscopy Cologuard Stool Cards

**Health Maintenance for Males. Please provide dates.**

Ever needed a bone density? **Y N** If Yes, when, why and treatment?_____

Last Colon Cancer Screening? _____ Please circle type: Colonoscopy Cologuard Stool Cards

Last Prostate Cancer Screening (PSA)? _____

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Sexually active? **Y N** Do you have children/how many? _____ Any childcare?_____

Tobacco Use? **Y N** Which types? _____How long? _____ How much per day?_____

Vaping or E-cigs? **Y N** How long?_____ Alcohol Use? **Y N** How much?_____

Use of THC products? **Y N** Edibles Inhaled Treating anything particular?_____

Use of illicit drugs currently? **Y N** Type:_____ History of illicit drug use? **Y N** Type:_____

Do you have any pets? **Y N** Smoke detectors in home? **Y N** Passive smoke exposure? **Y N** Any guns in the home? (this is a safety question, not reported to anyone) **Y N** If yes, locked? **Y N**

Do you use insect repellant regularly? **Y N** Sunscreen? **Y N**

How far did you go in school? _____

Do you have an advanced directive or living will? **Y N** Do you have a medical POA? **Y N**

Type of diet followed? _____How often do you exercise?_____

Do you live independently? **Y N** If No, who is your care provider?_____

Any vision problems? **Y N** Decreased hearing? **Y N** Difficulty remembering, or making decisions? **Y N**

Difficulty with 1) Dressing/Bathing? **Y N** 2) Running errands alone? **Y N** 3) Walking or climbing stairs? **Y N**

Gender Identity/Pronouns? _____ Sexual Preference?_____

Type of Birth Control? _____ Do you feel safe in your current relationship? **Y N**

Do you have difficulty paying utility bills? **Y N** Do you have a consistent place to live? **Y N**

Do you have enough food? **Y N** Do you feel safe in your current living situation? **Y N**

Do you have problems with transportation? **Y N**

Stress level? Low Medium High

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

| | None | 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 |

**Previous Doctor or Provider:**_____

**Reason for leaving:**_____

**Did anyone refer you to JFM?**_____

**Do you have others living in your home that also come to JFM?**_____

**Any specific concerns you need to address?**_____

Your Medical Records will be obtained from your previous provider once you have been accepted as a patient. Please do not request that your entire record be sent to us. If you have omitted any significant health information that we obtain after acceptance into the practice, you will likely be dismissed as intentional withholding of past medical history is not conducive to a therapeutic relationship.

By signing below, I agree that the above information is true and correct. I authorize Juniper Family Medicine (JFM) PLLC to leave voicemails at my primary phone number unless otherwise noted. By signing this, I also acknowledge receipt of our privacy act policy, HIPAA. Specifically, I authorize JFM providers to access the Colorado Prescription Monitoring Program which provides a record of past prescription medications. I also acknowledge JFM's use of the Quality Health Network, which is a highly secure database of protected health information which is solely used for transfer of said information to JFM and other medical professionals within a regional network. I give lifetime authorization for insurance payments to be made directly to JFM for services rendered by and related to JFM providers. I understand I am financially responsible for all charges, regardless of insurance coverage. In the event of non-payment, I agree to pay all costs of collections, which may include attorney's fees. I authorize JFM providers and staff to release all information necessary to secure insurance benefit payments. Lastly, I agree that a photocopy of this agreement shall be as valid as the original.

_____

Signature Date

Patient Name:_____DOB:_____

## Notice of Privacy Practices

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

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who are directly, and indirectly, involved in my care.
- 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 this Notice from time to time and that I may contact this organization at any time to obtain a current copy of this Notice.

**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 JFM is not required to agree to my requested restrictions, but if JFM does agree, JFM is bound to abide by such restrictions.**

_____

**Patient Signature** **Date**

## Authorization for Protected Communication

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

- Patient Portal – Please confirm email address_____
- Phone – Please confirm number_____
- Written Communication – Please confirm home address_____
- Other:_____

### Access to Information

JFM may share my medical information with the following person(s):

| Name | Relationship | Phone | Emergency Contact? |
|---|---|---|---|
| | | | |
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| | | | |

### Appointment Cancellation/No Show Policy Agreement

Appointment cancellations must be done 24 hours in advance. ***If you do not cancel within 24 hours, or no show, you will be charged $50 and the Physical exam no show fee is $100***. You will not be rescheduled until these fees are paid. If this occurs a third time, you will be dismissed. These fees are not paid by insurance. Lastly, if you fail to come for your first new patient visit, you will NOT be rescheduled and asked to seek care elsewhere.

_____

**Patient Signature** **Date**