Blue Springs Family Care, P.C.

104 NW State Route 7, Suite B
Blue Springs, MO 64014
Phone: (816) 229-8880 Fax: (816) 229-4363
www.bluespringsfamilycare.org

NEW PATIENT INFORMATION SHEET - Adult

______________________ ______________________ ________ ______________________
Last Name First Name MI Nickname

Gender ☐M ☐F ________-______-__________ ☐ Single ☐ Married _____/______/_________
Social Security Number ☐ Divorced ☐ Widow Date of Birth

Race: ☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other _____________ ☐ Decline to answer

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other ________________

______________________________ ________________ ________ __________
Address City State Zip

( ) ________-__________ ( ) ________-__________ ( ) ________-__________ _________
Home Phone Cell Phone Office Phone Ext.

E-Mail Address ______________________________

Daytime phone number that we can reach you at: ☐ Home ☐ Cell ☐ Work ☐ Other ________________

May we leave personal health information, including test results, on your answering machine?
Home - Yes ☐ *No* ☐ *Cell - Yes* ☐ *No* ☐ *Work - Yes* ☐ *No* ☐

Preferred contact method: ☐ *Phone* ☐ *Mail* ☐ *Email/Patient Portal*

Preferred reminder method: ☐ *Cell Phone* ☐ *Home Phone* ☐ *Work Phone* ☐ *Mail* ☐ *Email/Patient Portal*

If we are unable to contact you, may we mail your personal health information to your home address? Yes ☐ *No* ☐

Drivers License #/State ________________/_______

____________________________ Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed
Patient's Employer ☐ Self Employed ☐ Retired ☐ Student ☐ Other __________

I authorize the release of my medical information to the local HIE (Health Information Exchange) - Yes ☐ No ☐

I authorize the release of my immunization records to the local immunization registry - Yes ☐ No ☐

Whom may we speak with concerning your personal health information?
Spouse or Emergency Contact:

Last Name _________________________ First Name________________________ Date of Birth _____________

Primary Phone # ( ) ______-________ Home☐ Work☐ Cell☐ Secondary Phone # ( ) _____-_______Home☐ Work☐ Cell☐

Relationship to patient ________________ Address *(if different from patient)* ________________________________

Are there any restrictions on what information we can give them? ____

If there are other persons we can speak to concerning your personal health information, please list here:
Name ____________________________ Phone# _________________ Relationship ___________________
Name ____________________________ Phone# _________________ Relationship ___________________
Are there any restrictions on what information we can give them? ____

Pharmacy Name:__________________________ Address:______________________________________

Would you like information regarding an Advance Directive/Living Will? Yes ☐ No ☐ Already have one on file ☐

John Peterson, DO ▪ Tuongvan Tran, MD ▪ Stefany Hastings, FNP-C ▪ Kathrine Stipanovich, FNP-C ▪ Michelle Cass, FNP-C ▪ Amy Jensen, FNP-C

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Insurance Information

Primary Insurance Company ________________________________ Claims Phone # ( ) ______-________

Office Visit Co-Pay $______________ Effective Date ____________

Policy/ID # _________________________ Group # _______________

Claims Address ____

Policy Holder's Information: ☐ *Check here if patient is policy holder and skip this section*

Last Name __________________ First Name ____________________ Date of Birth _______________

Relationship to Patient _______________ Gender M/F Social Security # ______________________

Policy Holder's Address (If different from patient)____

Phone ( ) ______-________ Employer ______________________ Work Phone ( ) ______-________

Secondary Insurance Company _______________________________ Claims Phone # ( ) ______-________

Office Visit Co-Pay $______________ Effective Date ____________

Policy/ID # _________________________ Group # _______________

Claims Address ____

Policy Holder's Information: ☐ *Check here if patient is policy holder and skip this section*

Last Name __________________ First Name ____________________ Date of Birth _______________

Relationship to Patient _______________ Gender M/F Social Security # ______________________

Policy Holder's Address (If different from patient)____

Phone ( ) ______-________ Employer ______________________ Work Phone ( ) ______-________

AUTHORIZATION AND CONSENT

I request that all payment of authorized Medicare/Insurance benefits on my behalf be paid to Blue Springs Family Care, P.C. for all services rendered to me. I authorize any holder of medical information about me be released to the Centers for Medicare and Medicaid Services or any insurance company listed above or their agents in order to determine any benefits payable for related services. I authorize the release of health information as discussed in the privacy policies made available to me by BSFC.
I authorize Blue Springs Family Care, P.C. to access my medication history and formulary information through a secure electronic connection.
I understand that services for which I am treated may or may not be covered by my insurance company and/or Medicare. I am aware that I can be billed and am responsible for any existing or remaining dollar balance after all mandatory adjustments have been made to my account.
The privacy policies of BSFC have been made available to me for my review.
BSFC gladly accepts your check as payment. However, in an effort not to inconvenience you in the unlikely event that these funds are dishonored, we reserve the right to collect them electronically for the face value of the check, plus any applicable fees as permitted by state law.

Patient Signature_________________________________ Date____________________

Printed Name ___________________________ Patient Date of Birth _____/_____/________

If parent or guardian please state relationship to patient ________________________________

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HEALTH HISTORY

Name ____ Today's Date__________________

Age ____________ Birthdate ______________ Date of last physical examination ____________________

What is your reason for visit? ____

Symptoms – List symptoms you currently have or have had in the past year. __________________________

____

____

Females Only:

Date of last menstrual period ________________

Date of last Pap Smear ________________ Date of last mammogram?__________

Are you pregnant? ☐ Yes ☐ No Number of children _________

Conditions – Check conditions you have had in the past

☐Aids	☐Cataracts	☐High Cholesterol	☐Psychiatric Care
☐Alcoholism	☐Chemical Dependency	☐HIV Positive	☐Rheumatic Fever
☐Anemia	☐Chicken Pox	☐Kidney Disease	☐Seizure Disorder
☐Anorexia	☐Depression	☐Liver Disease	☐STDs (Sexually Transmitted Diseases)
☐Anxiety	☐Diabetes	☐Migraine Headaches	☐Stroke
☐Appendicitis	☐Emphysema	☐Miscarriage	☐Stomach Ulcers
☐Arthritis	☐Glaucoma	☐Mononucleosis	☐Suicide Attempt
☐Asthma	☐Gonorrhea	☐Multiple Sclerosis	☐Thyroid Problems
☐Bleeding Disorders	☐Gout	☐Mumps	☐Tuberculosis
☐Breast Lump	☐Heart Disease	☐Pacemaker	☐UTI (Frequent Urinary Tract Infections)
☐Bronchitis	☐Hepatitis	☐Pneumonia	
☐Bulimia	☐Hernia	☐Polio	
☐Cancer	☐Herpes	☐Prostate Problem	

IMMUNIZATIONS – If disease, put "D" and year. ☐ *Immunization record provided* *(do not need to fill out this section)*

Last year given	Last year given	Last year given
Tetanus __________________	Pneumonia _________________	Influenza ____________________
MMR ____________________	Pertussis __________________	Chicken Pox __________________

☐ Immunization record requested

Medications – List medications you are currently taking

Name __________________Dose _____________ Name ________________ Dose _______________

Name __________________ Dose _____________ Name ________________ Dose _______________

Name __________________ Dose _____________ Name ________________ Dose _______________

Allergies – List all allergies to Medications or Substances and your reaction to these

_______________________________________ ____________________________________

_______________________________________ ____________________________________

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Health Habits – Check which substances you use and describe how much you use.

☐Caffeine ______________ ☐Drugs _____________ ☐Tobacco _______________ ☐Other ___________

Occupational Concerns – Check if your work exposes you to the following:

☐Stress ☐ Hazardous Substances ☐ Heavy Lifting ☐ Other _______________________

Hospitalizations / Surgical History / Serious Illness / Injuries / Pregnancies

Year	Condition	Outcome	If Hospitalized – Hospital Name

FAMILY HISTORY – Fill in health information about your family. If unknown please write in "Unknown"

Relation	Age/year born	State of Health	Age at Death	Cause of Death	Diseases
Father					
Mother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Brothers					
Sisters					

Check if your blood relatives had any of the following diseases (this includes all aunts and uncles):

Relationship to you	Relationship to you
☐ Arthritis, Gout _______________________________	☐ Heart Disease, Strokes _________________________
☐ Asthma, Hay Fever __________________________	☐ High Blood Pressure ___________________________
☐ Cancer/ Location ____________________________	☐ Kidney Disease______________________________
☐ Chemical Dependency _______________________	☐ Tuberculosis ______________________________
☐ Diabetes _________________________________	☐ Other ______________________________

Patient Signature ____ Date __________________________

Printed Name ____ Patient Date of Birth ____/_____/_______

For Office Use Only:

☐ Physician reviewed Date _________________________ Initials _______________________