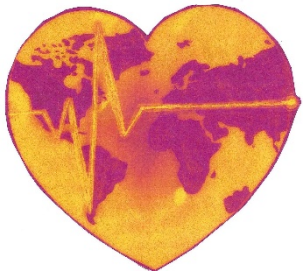

Beckett-Graves Health & Wellness
Concierge Health Maintenance Program
Patient Registration File & Health Questionnaire

Date: _____
Name: _____ Age: _____ DOB: _____
Address: _____
_____
Phone #: _____ Fax #: _____

Email Address: _____

Primary Insurance: _____ ID#: _____
Name of Provider: _____
Address: _____
_____
Main Telephone Number: _____
Provider Relations Telephone Number: _____
Fax Number: _____

Secondary Insurance: _____ ID#: _____
Name of Provider: _____
Address: _____
_____
Main Telephone Number: _____
Provider Relations Telephone Number: _____
Fax Number: _____

Source of Information: _____ Relation: _____
Reliability: _____

Social History
Age: ____ Gender: male ___ female ___ Resides In: Rural ___ Urban ___ Area
Marital Status: Married ___ Widowed ___ Divorced ___ Single ___
Resides with: ___ Spouse. ___ Children. ___ Other: _____

Occupation: _____ # of years: _____
Level of Education: ___ H.S. ___ Some college.___ Undergrad Degree. ___ Grad Degree

Any recent significant or stressful life events or situations? Yes ___ No ___ If yes, describe:

_____
_____
_____

Any leisure activities and/or hobbies? Yes ___ No___ If yes, describe:

_____
_____
_____

Religious Beliefs and/or Affiliations:

_____
_____

Allergies (Food, Medication, Environmental): _____
_____
_____
_____

Past Medical History:

Adult Illnesses (Check all that apply)

___ Diabetes
___ High Blood Pressure
___ Cancer: Type _____
___ Heart Disease
___ Heart Attack/MI
___ Stroke
___ Kidney Disease
___ Breast Disease: Type _____
___ Anemia
___ Thyroid Disorder: Type _____
___ High Cholesterol
___ Psychiatric Illness: Type _____
___ HIV
___ STD: Type _____
___ Genetic Abnormality
___ Asthma
___ COPD
___ Other: _____
___ Seizures/Epilepsy

Childhood Illnesses (Check all that apply)

___Measles ___Whooping Cough ___Scarlet Fever
___Mumps ___Chickenpox ___Polio
___Rubella ___Rheumatic Fever ___Other: _____

Family Medical History

___ Diabetes
___ High Blood Pressure
___ Cancer: Type _____
___ Heart Disease
___ Heart Attack/MI
___ Stroke
___ High Cholesterol
___ Psychiatric Illness: Type _____
___ HIV
___ STD: Type _____
___ Genetic Abnormality
___ Asthma

___ Kidney Disease
___ Breast Disease: Type _____
___ Anemia
___ Thyroid Disorder: Type: _____

___ COPD
___ Other: _____
___ Seizures/Epilepsy

_____	_____	_____	_____
Grandmother	Grandfather	Grandmother	Grandfather
Age:	Age:	Age:	Age:

_____	_____
Mother	Father
Age:	Age:

_____	_____	_____	_____	_____	_____
Sister	Brother	Sister	Brother	Sister	Brother
Age:	Age:	Age:	Age:	Age:	Age:

_____
Spouse
Age:

_____	_____	_____	_____	_____	_____
Daughter	Son	Daughter	Son	Daughter	Son
Age:	Age:	Age:	Age:	Age:	Age:

Nutrition

Type of Diet:_____ Restrictions: Yes ___ No ___
Use of caffeine: Yes __ No ___ If yes, specify _____
Dietary supplements: Yes ___ No___ If yes, specify_____
Recent weight loss/gain?Yes ___ No___ How much? _____ Intentional? Yes __ No___

Height: _____ Weight _____ BMI _____
Body Stature: Small Frame _____ Medium Frame _____ Large Frame _____

Safety

Safe Sex Practices: Yes ___ No ___
Smoke Detectors: Yes ___ No ___
Use of Seat Belts: Yes ___ No ___
Use of Sunblock: Yes ___ No ___
Use of Helmets: Yes ___ No ___
Guns located in the home: Yes ___ No ___ If yes, in safe place: Yes___ No___

Exercise

Exercise: Regularly? Yes ___ No ___ If yes, how much/how often?_____
_____
Type of Exercise: _____
History of Ortho Injuries:

1. Date: ___ Reason: _____
2. Date: ___ Reason: _____
3. Date: ___ Reason: _____

Immunizations

Completed Childhood Immunizations: Yes ___ No ___
Influenza: Yes ___ No ___ If yes, date: _____
Hepatitis B: Yes ___ No ___ If yes, dates: #1_____ #2_____ #3_____
Hepatitis B Titres: ___. If yes, dates: #1_____ #2_____ #3_____
Pneumococcal Vaccine: Yes ___ No ___ If yes, date: _____
Tetanus Diptheria Booster: Last given, date: ___ MMR Booster: Last given, date:___

Hospitalizations (Medical):

1. Date: ___ Reason: _____
2. Date: ___ Reason: _____
3. Date: ___ Reason: _____
4. Date: ___ Reason: _____

Hospitalizations (Psychiatric):

1. Date: ___ Reason: _____
2. Date: ___ Reason: _____
3. Date: ___ Reason: _____
4. Date: ___ Reason: _____

Surgical History

1. Date: ___ Reason: _____
2. Date: ___ Reason: _____
3. Date: ___ Reason: _____
4. Date: ___ Reason: _____

Substance Abuse:

Tobacco Use: Yes ___ No ___ If yes, cigarettes ___ or chewing ___?
Alcohol Use: Yes ___ No ___ If yes, how many/how often?_____
Drug Use: Yes ___ No ___ If yes, check all that apply: Marijuana __ Cocaine ___
Heroin ___ Other (specify) _____ Other (specify) _____
History of IV Drug use ___ Yes ___ No. Sharing of Needles ___ Yes ___ No.

Sexual History

1. Males & Females

Age at 1st Intercourse _____ Number of Partners ___

___ Vaginal intercourse Victim of Rape ___ Yes ___ No

___ Anal intercourse Victim of Sexual Abuse ___ Yes ___ No

___ Oral intercourse Past Prostitution ___ Yes ___ No

History of Unprotected Intercourse ___ Yes ___ No

Previous HIV Test ___ Yes ___ No

2. Females Only

Age at Menarch ___ Age at Menopause___ LMP: _____ Last Pap Smear: _____

Last Pelvic Exam: _____ Last Mammogram: _____ Last STD Screening _____

BSE: ___ Monthly ___ Occasionally ___ Not at all

Family history of breast cancer ___ Yes ___ No

Feminine hygiene: __ Douching __ Shower Gels __ Sprays __ Powder __ Bubble Bath __ Other: _____

___ # of Pregnancies ___ # of Miscarriages ___ # of Stillbirths ___ # of Live Births ___ # of Living Offspring ___ # of Abortions

Pregnancy Complications: _____

_____

_____

Sexual Intercourse With: ___ Males only ___ Females only ___ Males & Females

3. Males Only

TSE: ___ Monthly ___ Occasionally ___ Not at all

Last date of STD screening: _____

Sexual Intercourse With: ___ Males only ___ Females only ___ Males & Females

Health Maintenance

Last Dental Exam: Date _____ Last Vision Exam: Date _____

Last PAP Smear: Date _____ Last PSA test: Date _____

Last Mammogram: Date _____ Last Hearing Exam: Date _____

Last Urinalysis: Date _____

Last Stool for Occult Blood: Date _____

Last Baseline Labs: _____CBC _____ BMP _____ LFTs _____ CHO _____CMP

Beckett-Graves Health & Wellness
Authorization to Release Information

Patient Name: _____ Date of Birth: _____

This is an authorization to release information from _____ to Beckett-Graves Health & Wellness. It is intended for the use and/or disclosure of the following protected health information.

☐ Progress Notes
☐ Diagnostic procedures and reports
☐ Immunization records
☐ Laboratory testing reports
☐ Hospital discharge summaries
☐ All pertinent records

The signing of this authorization allows the staff of _____ to release the requested information to Beckett-Graves Health & Wellness. I understand that HIV and behavioral health information is further protected by State and Federal law and will not be further disclosed unless written authorization is expressly provided.

☐ Include behavioral health ☐ Do not include behavioral health
☐ Include HIV ☐ Do not include HIV

I further authorize release of health information to the following individuals:
Name: _____
Name: _____
Name: _____
Name: _____

By signing below, I certify that I understand the nature of this authorization and provide authorization for the release of my health information from _____ to Beckett-Graves Health & Wellness.

☐ Check if parent ☐ Check if guardian ☐ Check if self

_____ _____
Signature of Patient, Parents, or Guardian Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Beckett-Graves Health & Wellness Representative Date

1450 S. Havana Street, Suite 808, Aurora, CO 80012
Tele: 720-204-3351 ext 815, Urgent Call Line: 720-525-7997, Facsimile: 888-384-7012

Beckett-Graves Health & Wellness
Patient Rights and Responsibilities

Patient Rights: Our patients have the right to:

1. …equal access to quality care regardless of sex, disability, age, ethnicity, race, religion, national origin, or source of payment.
2. …to be treated with common courtesy, respect, and dignity.
3. …to have informed consent for, consent to, and be involved in health care decisions in partnership with the healthcare provider.
4. …to establish someone to take the role of a surrogate decision maker as permissible by law.
5. …to request assistance with and/or to form advanced directives that will govern my health care with of them considered and honored.
6. ...to refuse any type of care or treatment.
7. …to be transferred to a different medical facility of choice when feasible per medical stability.
8. **…**privacy not only during care, but also thereafter with the use of information about care having all communication and records treated in a confidential manner.
9. …access to health information and the medical record at any time per HIPPA laws and regulations.
10. …safety during care per general safety practices in the facility and immediate environment.
11. …consult with a specialist as deemed necessary.
12. …to have assistance with the overcoming of language barriers through visitors, use of the telephone, other interpreter services, or mail.
13. …to be informed of the professional status and identity of anyone providing care.
14. …the right to be informed upon request of any type of treatment prior to the initiation of that treatment for anticipated charges with the right to receive and evaluate of itemized bill explaining services rendered and eventual charges.
15. …to have any family member or other representative present during care

Patient Responsibilities: Our patients have the responsibility:

1.…of the resultant medical consequences of refusing treatment.

2.…of providing complete and accurate information regarding health status.

3.…of following the recommended treatment plan per care provided.
4.…to fulfill any financial obligations related to care provided.
5.…to common courtesy, respect, and consideration of Beckett-Graves Health & Wellness staff and patients.
6.…of asking questions during care or thereafter if any part of the treatment plan is not fully understood.

Grievance Procedure

Whenever concerns arise regarding patient care, feel free to consult your healthcare provider for resolution of the issue.

ACKNOWLEDGEMENT OF RECEIPT

I have read and understand that above information explaining the privacy practices of Beckett-Graves Health & Wellness. I understand the above rights and responsibilities.

_____ _____
Patient/Patient's Legal Representative/Relationship Date

_____ _____
Witness Date

Beckett-Graves Health & Wellness
Notice of Privacy and Protected Health Information Practices

WHAT IS PROTECTED HEALTH INFORMATION OR PHI?

PHI is health information that specific to an individual which identifies that individual in business related to the care and treatment of that individual as well as payment for services rendered implement care and treatment.

Patient Rights/Responsibilities	Beckett-Graves Health & Wellness Responsibilities/Other Use & Disclosure Regulations
Rights • Receive a Notice of Privacy Practices • Request amendments to your information • Access for review and copies of your information • Request multiple avenues for communication • Request a list of disclosures made • Arrange for restrictions on disclosures • File an official complaint in writing regarding any grievances • To authorize disclosures for: - Attorneys - Treatments via research - Fundraising purposes - Marketing purposes	**Responsibilities** • Utilize safeguards through PHI Protection policies and procedures • Utilize the minimum amount of PHI necessary for any particular task • Adhere to privacy policies **Other Use & Disclosure** • Following are agencies which require approval for disclosures: - FDA - Law Enforcement - Public Health department - Protective organizations - Military • Following are types of requests for which patient authorization is not required: - Treatment - Payment - Healthcare operations - National security - Law compliance - Healthcare oversight agencies - Funeral directors or coroner - Corrections

ACKNOWLEDGEMENT OF RECEIPT

I have read and understand that above information explaining the privacy practices of Beckett-Graves Health & Wellness (BGHW). I understand that my information will be used without my consent or authorization for treatment, payment, and administrative purposes. I understand that BGWH uses data, digital signature, and software encryption services further protecting my information in all electronic forms. Any other use of my information will not be permitted without written consent or authorization. I have received a copy of this notice of privacy practices. I understand that I may contact the center at any time with any questions or concerns regarding the above information.

_____ _____

Patient/Patient's Legal Representative/Relationship Date

_____ _____

Witness Date

Beckett-Graves Health & Wellness
A Subsidiary of Naypree Enterprises, LLC

Consent for Case Management Services, Healthcare, and Assistance With Change of Healthcare Plan/Provider

_____ I agree that I and/or my child _____ will be provided assistance with changing of our healthcare provider by Beckett-Graves Health & Wellness

_____I agree that (and/or my child _____will be provided case management services by Beckett-Graves Health & Wellness providing assistance with change of medical coverage plan and provider, medical needs, transportation needs, care coordination* and other services otherwise difficult to obtain for my family.

_____ I certify that I am the _____(relationship) of the above-mentioned individual.

_____ I consent to examination and treatment including, but not limited to taking bodily samples, specimens, or cultures for lab tests as deemed necessary for the provision of providing quality healthcare. agree to release and hold harmless Naypree Enterprises, Beckett-Graves Health & Wellness and its affiliates, its agents, its contractors, and/or employees from any liability for physical injuries suffered as a result of any tests, treatments, exams or any other service received.

_____ This consent shall apply to all provided healthcare and case management services as deemed necessary by the assigned case manager indefinitely until such time as I decide to terminate it.

_____ _____
Patient/Legal Representative Print Name Patient/Legal Representative/Sign Name

_____ _____
Witness Print Name Witness Sign Name

_____
Beckett-Graves Health & Wellness Rep Print Name

_____
Beckett-Graves Health & Wellness Rep Sign Name

_____
Date