

**PATIENT DEMOGRAPHIC INFORMATION**

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: Male Female Race (*circle one*): Caucasian Hispanic Other \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Preferred Phone: ( ) \_\_\_\_\_ Texting? Yes No Zip Code: \_\_\_\_\_

Secondary Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ OK to email? Yes No

Employer & Address: \_\_\_\_\_

Parent/Spouse/Guardian Name: \_\_\_\_\_ Marital Status: Married Single Divorced Widowed

Other family members that have been seen in our office:  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone (1): \_\_\_\_\_ Phone (2): \_\_\_\_\_ Email: \_\_\_\_\_

Pharmacy you use: \_\_\_\_\_ City: \_\_\_\_\_

*I came here because of a: (circle one)* Doctor Family Friend Community Event Internet Banner Radio  
Billboard Mailer Phone Book TV Newspaper Other Name: \_\_\_\_\_

**Primary Insurance Policy Holder Information / Guarantor**

Policy Holder name: \_\_\_\_\_ Phone: \_\_\_\_\_ SSN ----- \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient: \_\_\_\_\_

Employer & Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this person the GUARANTOR on the account? Yes No

**Secondary Insurance**

Policy Holder name: \_\_\_\_\_ Phone: \_\_\_\_\_ SSN ----- \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient: \_\_\_\_\_

Employer & Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

All Previous Providers: \_\_\_\_\_

**CURRENT MEDICATIONS & DOSAGE** (Please list type & dosage)

- 1. Medication \_\_\_\_\_ Dosage/how often \_\_\_\_\_
- 2. Medication \_\_\_\_\_ Dosage/how often \_\_\_\_\_
- 3. Medication \_\_\_\_\_ Dosage/how often \_\_\_\_\_
- 4. Medication \_\_\_\_\_ Dosage/how often \_\_\_\_\_

**ALLERGIES WITH REACTIONS**

- 1. Allergy \_\_\_\_\_ Reaction \_\_\_\_\_ Severity \_\_\_\_\_
- 2. Allergy \_\_\_\_\_ Reaction \_\_\_\_\_ Severity \_\_\_\_\_
- 3. Allergy \_\_\_\_\_ Reaction \_\_\_\_\_ Severity \_\_\_\_\_

**PROCEDURES?** Please list the date of your most recent:

- 1. PAP: date \_\_\_\_\_ 2. Mammogram : date \_\_\_\_\_
- 3. Colonoscopy : date \_\_\_\_\_
- 4. Hospitalization : date \_\_\_\_\_ reason \_\_\_\_\_

**SURGERIES?**

- 1. year \_\_\_\_\_ type \_\_\_\_\_
- 2. year \_\_\_\_\_ type \_\_\_\_\_
- 3. year \_\_\_\_\_ type \_\_\_\_\_

Former smoker? \_\_\_ Yes \_\_\_ No How long? \_\_\_\_\_

Do you use chewing tobacco or snuff? \_\_\_ Yes \_\_\_ No How much per day? \_\_\_\_\_

Do you smoke cigars or cigarettes? \_\_\_ Yes \_\_\_ No How many per day? \_\_\_\_\_

Do you drink (circle) beer/wine/liquor? How many per day/week/month? \_\_\_\_\_ No

Have you used any illegal or addictive drugs? \_\_\_ Yes \_\_\_ No Type: \_\_\_\_\_

**WOMEN ONLY – PREGNANCY HISTORY**

Indicate quantity in the box:

Total pregnancies	Full Term	Premature	Induced abortion	<input type="text"/>
Spontaneous abortion	Ectopic	Multiple Birth	Living	<input type="text"/>

Date of last menstrual period \_\_\_\_\_

# TRIPP FAMILY MEDICINE

Today's Date: \_\_\_\_\_

**\*\*\*\*\*CIRCLE SELF OR FAMILY MEMBER AND LIST SPECIFIC DISEASE**

DISEASE	FAMILY MEMBER		SPECIFY DISEASE
Acne	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Alzheimer's/Dementia	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Anemia/Bleeding Problems/Blood Disorder	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Arthritis (Osteo / Rheumatoid)	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Asthma/Bronchitis/COPD/ Emphysema	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Cancer (Skin, Colon, Lung, Breast, Ovarian, Other)	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Depression/Anxiety/ Other Mental Illness	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Diabetes	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Drug or Alcohol Dependency	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Heart Attack/Angina/Stroke	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Heart Burn/GERD	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Kidney/Hepatitis/Liver Disease	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
High Blood Pressure	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
High Cholesterol	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Intestinal/Stomach/Ulcers	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Urinary Disorders	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Osteoporosis	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Seizure Disorder	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Skin Disorder	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Thyroid Disease	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Tuberculosis	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	
Other (please describe)	SELF Mom Dad Brother Sister	Paternal Gma or Gpa Maternal Gma or Gpa	

*I certify that the above medical history information is accurate and correct:*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# TRIPP FAMILY MEDICINE

Today's Date: \_\_\_\_\_

1411 Fillmore St., Suite #600, Twin Falls, ID 83301  
Phone 208-933-4400 Fax 208-933-4401

## 1. AUTHORIZATION OF TREATMENT:

12/2015

I authorize **Tripp Family Medicine** to provide medical services to myself or my legal dependent, \_\_\_\_\_ . I understand I have the right to refuse medical services at any time. I further understand no guarantees have been made by any representative of Tripp Family Medicine as to the outcome of medical services provided.

Initials: \_\_\_\_\_

## 2. BENEFITS RELEASE INFORMATION:

I authorize **Tripp Family Medicine** to release information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorized the payment of medical benefits for these services to be paid directly to Tripp Family Medicine. If any payment is made directly to me by my insurance company, I will remit that payment to Tripp Family Medicine immediately.

Initials: \_\_\_\_\_

## 3. FINANCIAL RESPONSIBILITY:

I am or \_\_\_\_\_ (the guarantor) is the person financially responsible for any debt in relation to service provided. I understand and agree to pay all insurance co-pays and amounts due for services not covered by insurance in advance at time of service, (these services may include after hour visits, urgent office visits, extended office visits, procedures and injections). I understand and agree that, except as otherwise provided by law, I am obligated to pay charges that are not paid by my insurance company. I am responsible for all costs of collecting monies owed, including court costs, collection agency fees, phone fees, and attorney fees. Any balances not paid within 90 days, will be subject to 15% interest (APR). A payment resulting in a credit less than \$40 and not applied to a service is refundable upon my written request. Credits less than \$40 will be held for 24 months then forfeited, if not requested in writing.

Initials: \_\_\_\_\_

## 4. CONTACT POLICY:

I agree, in order to service my account(s), including all past, current and/or dependent accounts, or to collect any amounts I may owe for any past or current account(s), **Tripp Family Medicine** or their representative may contact me by telephone at any telephone number, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or e-mails to any of my phone numbers or e-mail accounts. Methods of contact may include using pre-recorded/artificial voice messages and/or use or an automatic dialing device, as applicable.

Initials: \_\_\_\_\_

# TRIPP FAMILY MEDICINE

Today's Date: \_\_\_\_\_

## 5. ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

- No one, other than myself, my insurance and authorized medical staff can discuss my PHI.
- Yes, I grant permission to Tripp Family Medicine and the person(s) listed on the Consent to Release Form access to my PHI. (see attached)

Initials: \_\_\_\_\_

## 6. CANCELLATION AND NO-SHOWS:

We require 24 hours' notice of a cancellation. Not showing up, or showing up late, for my appointment can greatly affect the success of my treatment and not allow other patients the opportunity to be seen in a timely manner. I am aware there is a \$50 charge for a cancellation or no show without proper notice, which is not covered by insurance and will be paid by me.

Initials: \_\_\_\_\_

## 7. HIPAA CONSENT OMNIBUS (Consent for use and Disclosure of Health Information):

I have had full opportunity to read and consider the contents of the Notice of Privacy Policies and Practices for Tripp Family Medicine. I understand that, by signing this consent form, I am giving my consent to your (TFM) use and disclosures of my protected health information to carry out treatment, payment activities and healthcare operations.

### RIGHT TO REVOKE

Written notice of revocation is required, and please note that as a result of revocation is required, and please note that as a result of revocation, Tripp Family Medicine may decline to treat me or continue my treatment.

Initials: \_\_\_\_\_

I, (print name) \_\_\_\_\_, have read, understand,  
and agree to all 7 of the above statements, either for myself  
or \_\_\_\_\_, (dependent) and will adhere to the above policies.

Signature: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*(If the consent is signed by a personal representative on behalf of the patient, complete the following: )*

Personal Representative's Name: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

*For Tripp Family Medicine Use Only*

Witness \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



**PROTECTED HEALTH INFORMATION (PHI)  
AUTHORIZATION FOR ADULT PROXY ACCESS**

This form is to be completed by a patient over the age of eighteen (18yr) who wishes to grant another adult with proxy access to their Medical records, including billing, in both written and verbal format.

This form is not valid if altered.

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:	City:	State:	Zip Code:
Telephone Number(s):	Cell:	Home:	Work:
Other Names under which patient has been treated:			

ADULT PROXY INFORMATION (18yrs or older)			
Proxy Name:		Date of Birth:	
Telephone Number(s):	Cell:	Home:	Work:
Relationship to Patient: <input type="radio"/> Spouse/Partner <input type="radio"/> Parent/Guardian <input type="radio"/> Adult Child <input type="radio"/> Other			
If Other, please specify:			

\_\_\_\_\_ I choose NOT to have any proxy for my account. I will not have anyone schedule appointments, call, pay my bill, or assist in my care.

**Please read and initial each statement, signifying understanding of each statement.**

\_\_\_\_\_ I hereby authorize Tripp Family Medicine, Inc. and any of its affiliated entities, employees, agents, or associated health care practitioners to allow the above named individual to access my protected health information as my designated proxy. I understand that this authorization will remain valid and in effect until affirmatively revoked by me, in writing.

\_\_\_\_\_ I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, I must submit a written revocation to Tripp Family Medicine, Medical Records at any Tripp Family Medicine facility.

\_\_\_\_\_ I understand that information disclosed by Tripp Family Medicine's pursuant to this authorization may be re-disclosed by the individual that receives this information and may no longer be protected by privacy regulations. I understand the information that my proxy will be able to access may include records related to behavioral/mental health care, alcohol/drug abuse treatment, sexual testing/HIV/AIDS, and genetics. I also understand that my health care cannot be conditioned upon my execution of this authorization.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date/ Time

\_\_\_\_\_  
Witness of Signature

\_\_\_\_\_  
Date/ Time