



Patient Name: _____

INTRODUCTION

This is a comprehensive Teenage history questionnaire that I have designed to help me provide you with your health assessment, diagnosis and treatment. I realize that the form is long and *it will require considerable time to complete in a detailed fashion.*

It is important that you take the time to read and *thoroughly answer each and every question* to the best of your ability. Some of the question's may not seem pertinent to you, yet each and every question is designed to provide me with information regarding your health. Some questions may not appear health related, yet each question provides me with information that will guide me in your health care. If you do not understand a question, please mark it with a "?" mark.

Your honesty and completeness will help me provide you with the best care possible.

It is important that you answer all questions on the form. Remember, it is your health and life that is at issue.

Many times, talking with family members will be helpful in completing this form. Please get all the assistance you can when completing the form but do not have someone else complete the form. Even the appearance of your handwriting helps me assess your health.

Bring the completed form with you to your first appointment. Please make ever effort to have the form completed before your appointment.

Do not attempt to complete the form while in the office.

Please describe what problem brought you to see Dr. Bereznoff today:

Physician notes: do not write in this area



Patient Name: _____

Who Referred you to Dr. Bereznoff ? _____

SEXUAL PREFERENCES

- heterosexual (opposite sex only) homosexual (same sex only) bisexual (either /both sexes) abstinent

EDUCATION circle highest level achieved

grade 6 7 8 9 10 11 12 GPA _____

What is your favorite area of study? _____

BIRTH PLACE

EXERCISE Do you exercise for 20 minutes 3 or more times per week?

- YES NO

If you answered yes please describe what type of exercise, how often and for what duration

Physician notes: do not write in this area

DIET Do you follow any special diet YES NO
If yes, please describe

CAFFEINE Do you drink COFFEE, SODAS, TEAS or use CAFFEINE SUPPLEMENTS? YES NO
If yes, please describe what, how much and how often.

TOBACCO

Do you *currently* use tobacco products YES NO

Have you used tobacco in the *past* YES NO

Please describe the type of tobacco, the amount consumed, dates used and the frequency of use

ALCOHOL

Do you *currently* drink any alcoholic beverages YES NO

Have you used alcoholic products *in the past* YES NO

Please describe the type of alcohol, the amount consumed and how often:



Patient Name: _____

DRUGS

Do you **currently** use Recreational or STREET DRUGS YES NO

have you used Recreational or STREET DRUGS products *in the past* YES NO

Please describe the type of drug, the amount consumed, dates used and the frequency of use

Physician notes: do not write in this area

HOBBIES / SPORTS Please list any past or present hobbies / sports

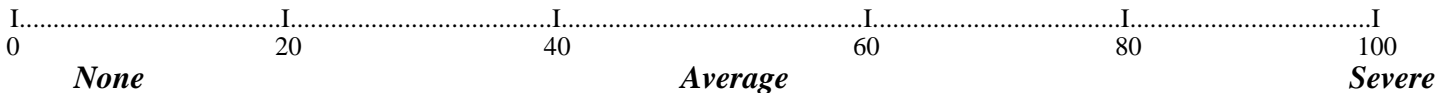
LIVING ARRANGEMENTS Please describe your current living situation, including a list of all people currently living in your home:

PETS Please list any and all pets of all types living in or at your home:

RELIGION Please describe what your religious affiliation may be and what your beliefs are regarding your religion:

STRESS

please place an "X" on the scale where you believe your stress level has been during the past 6 months



Please describe what you most bothersome stressors are:



Patient Name: _____

Your Family History

Place a ✓ mark in the box if your relative had/ has this problem

Relationship	current age	✓ if currently living	Age at death	cancer	diabetes	heart attack	elevated cholesterol	blood pressure	strokes	migraines	alcohol abuse	depression	drug abuse	nerve disease	brain disease	kidney disease	bladder disease	thyroid disease	asthma, lung disease	heart disease	colon disease	arthritis	pancreas disease	stomach disease	glaucoma	anemia / leukemia	Other
FATHER																											
FATHERS FATHER																											
FATHERS MOTHER																											
MOTHER																											
MOTHERS FATHER																											
MOTHERS MOTHER																											
AUNT																											
AUNT																											
AUNT																											
UNCLE																											
UNCLE																											
UNCLE																											
BROTHER																											
BROTHER																											
BROTHER																											
SISTER																											
SISTER																											

Your Individual Health History

Your Birth Date _____ / _____ / _____

Your History of Contagious Diseases

Please mark all that you have experienced with an "✓"

- | | | | | | |
|--|---------------------------------------|---|---|---|--------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Polio | <input type="checkbox"/> German measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough | |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sexually transmitted disease | | |
| <input type="checkbox"/> Other _____ | | | | | |

Physician notes: do not write in this area



Patient Name: _____

History of past or current illnesses that you have been DIAGNOSED with having

Please mark all that you have experienced with an "✓"

- | | | | | | |
|---|---|---|--|--|--|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> migraines | <input type="checkbox"/> heart disease | <input type="checkbox"/> gout | <input type="checkbox"/> ulcers | |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> epilepsy | <input type="checkbox"/> seizures | <input type="checkbox"/> asthma | |
| <input type="checkbox"/> blood disorder | <input type="checkbox"/> anemia | <input type="checkbox"/> glaucoma | <input type="checkbox"/> cancer | <input type="checkbox"/> nerve disease | <input type="checkbox"/> alcohol problem |
| <input type="checkbox"/> drug abuse | <input type="checkbox"/> mental illness | <input type="checkbox"/> tumors | <input type="checkbox"/> eczema | <input type="checkbox"/> herniated disc | <input type="checkbox"/> drug problem |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> digestive problems | <input type="checkbox"/> emphysema | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> pancreatitis | <input type="checkbox"/> depression |
| <input type="checkbox"/> obesity | <input type="checkbox"/> kidney disease | <input type="checkbox"/> gallbladder | <input type="checkbox"/> liver disease | <input type="checkbox"/> anxiety | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> kidney stones | <input type="checkbox"/> eating disorder | | <input type="checkbox"/> cataracts | |
| <input type="checkbox"/> polyps | <input type="checkbox"/> gallstones | <input type="checkbox"/> inherited problems | | <input type="checkbox"/> rheumatic fever | |
| <input type="checkbox"/> back problems | <input type="checkbox"/> other _____ | | | | |

Preventative Medical History

- | | | |
|--|-------|--|
| Date of your last PAP / Pelvic exam (women only) | _____ | <input type="checkbox"/> check here if you have never had this test |
| Date of your last TB test | _____ | <input type="checkbox"/> check here if you have never had this test |
| Date of your last Tetanus vaccination | _____ | <input type="checkbox"/> check here if you have never had this vaccination |
| Date of your last Pneumococcal vaccination | _____ | <input type="checkbox"/> check here if you have never had this vaccination |
| Date of your last Hepatitis A vaccination | _____ | <input type="checkbox"/> check here if you have never had this vaccination |
| Date of your last Hepatitis B vaccination | _____ | <input type="checkbox"/> check here if you have never had this vaccination |
| Date of your last influenza (Flu) vaccination | _____ | <input type="checkbox"/> check here if you have never had this vaccination |

Please Provide a copy of any and all other vaccinations you have received

Accidents, Fractures, Car or Motorcycle Accidents

type of accident and injury sustained	date	treatment
1		
2		
3		
4		

History of Surgeries

type of surgery	date	treatment
1		
2		
3		
4		



Patient Name: _____

Hospitalizations

reason	date	treatment
1		
2		

Known Drug or Medication Allergies

Name of Medication	date	reaction
1		
2		

Food Allergies

Name of food	date	reaction
1		
2		

Environmental Allergies (dust, grass, trees, etc.)

1		
2		

Commercial product Allergies (cleansers, make-up, cleaners etc.)

1		
2		

LIST OF CURRENT PRESCRIPTION MEDICATIONS

medication	dose	times a day	why taken

LIST OF CURRENT VITAMINS / MINERALS

What	dose	times a day	why taken



Patient Name: _____

LIST OF CURRENT HERBAL OR HOMEOPATHIC MEDICATION

What	dose	times a day	why taken

SYMPTOM REVIEW Please check the appropriate box for each of the following symptoms that are a *problem* for you.

If the symptom is very rare or occurred long ago, do not check it

general:

- recent weight loss
- weakness
- fever, chills
- loss of appetite
- sleeping problems
- weight gain
- fatigue
- night sweats
- excess appetite
- passing out

head:

- headaches
- Head injuries
- skull fracture
- loss of hearing
- ear pain
- loss of consciousness
- brain injuries
- ringing in ears
- ear discharge

eyes:

- blurred vision
- glasses or contact lenses
- blind spots
- itching
- dryness
- double vision
- sensitivity to light
- loss of vision
- redness
- tearing
- pain
- color blindness
- night vision problems

nose:

- decreased smell
- abnormal smells
- post nasal drip
- sneezing
- loss of smell
- bloody discharge
- congestion
- broken nose

mouth:

- bleeding gums
- grinding teeth
- clenching jaws
- cold sores or fever blisters
- sore tongue
- dental problems
- pain

throat:

- sore throat
- difficult swallowing
- hoarseness
- pain
- lump in throat
- change in voice

neck:

- stiffness
- soreness

- pain
- click or grinding
- thyroid problems
- Loss of motion
- Lumps or swelling

lungs:

- cough
- wheezing
- exposure to tuberculosis
- wet
- dry
- blood with cough
- short of breath

heart:

- chest pain at rest
- chest pain with activity
- breathing problems at night
- swollen legs, ankles or feet
- heart pounding, fluttering, racing
- skipping heart beat
- history of scarlet fever/rheumatic fever
- heart murmur
- high blood pressure

blood vessels:

- painful or swollen veins
- leg pain or cramps
- at rest
- night
- walking
- leg ulcers
- blue or cold fingers or toes

stomach and intestines:

- abdomen or stomach pains
- nausea, vomiting,
- excessive belching
- excessive passing gas
- heartburn
- difficult or painful swallowing
- food sticking
- change in bowel habits,
- how often do you have a bowel movement ?

- any change in size, shape, color or frequency of bowel movement
- blood in stools
- laxative use
- diarrhea
- clay color stools
- enema use
- constipation

- pain in rectum
- tea colored urine
- history of hepatitis
- change in weight or appetite
- get full to easy after eating
- abdomen cramping
- rectal spasms
- bloating

urine:

- blood in urine
- burning or painful urination
- foul smelling urine
- abnormal urgency to urinate
- how many times do you urinate at night _____
- how many times do you urinate in the day _____
- hesitancy, dribbling, of urine
- loss or urine with coughing / sneezing

bones and joints:

- back or neck pain
- stiffness
- hot joints
- loss of use of muscles
- muscle or joint pain
- weakness
- red joints
- swollen joints
- muscle cramps

nerves:

- seizures
- spasms
- lightheaded
- tremors
- loss of feeling
- tingling
- balance problems or coordination difficulty
- loss of consciousness
- double vision
- ticks
- dizziness
- shakes
- abnormal feeling
- headaches

glandular:

- tiredness without apparent reason
- night sweats
- heat or cold intolerance
- any change in: hair voice nails breasts testicles
- excessive thirst

blood:

- anemia



Patient Name: _____

Do not write in this area
Physician Notes:



Patient Name: _____

REGISTRATION FORM (Please Print)

Today's Date ____/____/____

PATIENT INFORMATION

Patient's Last Name			First	Middle	Mr. Mrs. Dr.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name? Yes No	If not, what is your legal name?		(Former Name)		Birth Date / /		Sex M F
Street Address		City	State	ZIP Code	Social Security		Home Phone No. ()
P.O. Box		City		State	ZIP Code		
Employer					Address		Employer Phone No. ()

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date /	Address (if different)			Home Phone No. ()
Is this person a patient here?	Yes No				()
Employer	Employer Address			Employer Phone No. ()	
Is this patient covered by insurance? Yes No					
Please indicate Primary insurance					
Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #	
/ /					
Relationship to Subscriber	Self	Spouse	Child	other	
Subscriber's Name		Group #		Policy #	
Patient's Relationship to Subscriber	Self	Spouse	Child	other	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance or charges denied by the insurance company. I also authorize Craig Bereznoff, D.O. or my insurance company to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE _____

DATE _____



Patient Name: _____

PATIENT FINANCIAL POLICY FORM

Thank you for choosing Dr. Craig M Bereznoff to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign.

All new patients must complete our Patient Registration form as well as our Financial Policy before seeing the physician.

- CO-PAYS AND/OR DEDUCTIBLES ARE DUE IN FULL AT THE TIME OF SERVICE
- FOR YOUR CONVENIENCE, WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD
- PAYMENT PLANS ARE ACCEPTED UPON APPROVAL
- FAILURE TO SHOW FOR A NEW PATIENT VISIT WILL RESULT IN A \$135.00 FEE AND WE WILL NOT ACCEPT ANY FURTHER REQUESTS FOR AN APPOINTMENT
- FAILURE TO SHOW FOR A REGULARLY SCHEDULED APPOINTMENT WILL RESULT IN A \$35.00 FEE
- THERE IS A \$35.00 RETURNED CHECK FEE FOR NON-SUFFICIENT FUNDS

REGARDING INSURANCE:

Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. We will bill your insurance plan for you, as long as you provide us with the correct information. Please be aware that some, or perhaps all, of the services provided may be deemed non-covered services and /or not considered medically necessary by your health insurance plan.

You, as the patient, are ultimately responsible for payment of all services provided by our office. In the event that your insurance coverage changes to a plan where we are not participating in, your insurance may not cover any charges.

While payment is your responsibility, we will assist you in negotiating with your insurance company for any disputed claim.

Our Patient Accounts department is available to discuss any questions you may have regarding your insurance or your account.

All co-pays and deductibles are due the day of treatment..

If you have a secondary insurance we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

If you bill any insurance yourself, please do so promptly, so that you will receive reimbursement before your account is considered delinquent.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will still be responsible for the bill.

CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days, subject to collection action and interest charged at %18 per annum.

COLLECTIONS:

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Patient Accounts department as soon as possible.

If an account becomes excessively over due, necessary action will be taken to recover the account balance due and you will be discharged from our medical care.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have fully read and understand the Financial Policy. I understand and agree to this Financial Policy.

X _____ Signature of Patient or Responsible Party

Date: ___/___/_____



Patient Name: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date 01 April, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Craig M. Bereznoff, D.O. at 303-776-3202. This notice describes the privacy practices at our office.

We are required by law to:

Maintain the privacy of protected health information.
Give you this notice of our legal duties and privacy practices regarding your health information
Follow the terms of the notice currently in effect.

How we may use and disclose your health information.

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Craig M. Bereznoff, D.O.

Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.



Patient Name: _____

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to Craig M. Bereznoff, D.O.. **Right to Amend.** You have the right to request an amendment to your records by written request to Craig M. Bereznoff, D.O.

Right to an Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Craig M. Bereznoff, D.O.

Right to Request Restrictions. You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Craig M. Bereznoff, D.O..

We are not required to agree with your request, but we will try to comply. You have the right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Craig M. Bereznoff, D.O. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to:

Craig M. Bereznoff, D.O., L.L.C.
1304 N. Vivian St
Longmont, Colorado USA
ph 303-776-3202 fax 303-772-3214



Patient Name: _____

Approval for Release of Information to Individuals:

Our physicians and staff maintain the highest level of patient confidentiality. You may choose to designate 1 or 2 individuals (other than physicians) to whom we may release information regarding your treatment, finances or special needs.

Last Name: _____ First Name: _____

Phone Number: (____) _____ Relationship: _____

Last Name: _____ First Name: _____

Phone Number: (____) _____ Relationship: _____

Patient / Gardian Signature: _____ Date: ____/____/____

Acknowledgement of Receipt of Notice of Privacy Practices:

I have received a copy of Craig M. Bereznoff, D.O.'s Notice of Privacy Practices.
If I have any questions or concerns about this policy, they will be addressed to the clinic in writing.

Patient / Gardian Signature: _____ Date: ____/____/____

**FOR YOU APPOINTMENT
PLEASE BRING ALL PRESCRIPTION BOTTLES
AND ALL INSURANCE CARDS**



Patient Name: _____

RECORDS RELEASE

TO: _____

I HEREBY AUTHORIZE YOU TO RELEASE TO:

Craig M. Bereznoff, D.O.
1304 N. Vivian St.
Longmont, Colorado, 80501-3217
ph 303-776-3202 fax 303-772-3214

Photocopies or discussion of information to be released:

- G Medical Records of the past _____ years of treatment
- G Psychological or psychiatric conditions, if any
- G All records in the Patient Record (excluding records received from other sources)
- G All records generated by this facility including Substance abuse, Drug or Alcohol abuse, if any
- G Genetic tests and records pertaining to genetic testing AIDS / HIV, if any
- G Other (Specify) _____

This information if needed is for the following purpose(s)

- G Transferring care
- G Consultation
- G Other _____
- G Expiration or revocation of authorization. _____
- G I understand that I may revoke this authorization at any time.

Printed Patient Name _____ Soc. Sec. # _____ D.O.B. _____

Signature of Patient or Gardian _____ Date: _____

Witness _____ Date: _____

There is no charge when records are sent to a physician for continuing care.
A copy fee is charged when records are released to a non-physician recipient.
RECORDS ARE ONLY RELEASED UPON RECEIPT OF WRITTEN AUTHORIZATION

