Christopher Cooper, M.D.
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Jodie Carpenter, FNP-C

Fellows, American Academy of Family Practice and American College of Physicians
199 S. McCleary Road, Suite 100, Excelsior Springs, MO 64024 **P** 816-407-4700 **F** 816-407-4701 libertyhospital.org

Patient

LAST NAME FIRST NAME MIDDLE NAME PREVIOUS LAST NICKNAME

SOCIAL SECURITY BIRTHDATE SEX

BILLING ADDRESS STREET CITY STATE ZIP CODE

COUNTY RACE LANGUAGE ETHNICITY

MARITAL STATUS PRIMARY CARE PROVIDER

HOME PHONE NUMBER DAY PHONE NUMBER CELL PHONE NUMBER

ALTERNATE PHONE FOR EMERGENCY E-MAIL

Insurance

PAYER NAME

ADDRESS CITY STATE ZIP CODE

PLAN NUMBER POLICY NUMBER

GROUP NAME GROUP NUMBER EFFECTIVE DATE

SIGNATURE DATE

Guarantor: Person Responsible for this Account

LAST NAME FIRST NAME MIDDLE NAME PREVIOUS LAST NICKNAME

SOCIAL SECURITY BIRTHDATE SEX

☐ CHECK IF ADDRESS IS SAME AS PATIENT

BILLING ADDRESS STREET CITY STATE ZIP CODE

COUNTY RACE LANGUAGE ETHNICITY

MARITAL STATUS PRIMARY CARE PROVIDER

HOME PHONE NUMBER DAY PHONE NUMBER CELL PHONE NUMBER

ALTERNATE PHONE FOR EMERGENCY E-MAIL EMPLOYER

INSURANCE HOLDER ☐ YES ☐ NO

Additional Parent

LAST NAME FIRST NAME MIDDLE NAME PREVIOUS LAST NICKNAME

SOCIAL SECURITY BIRTHDATE SEX

☐ CHECK IF ADDRESS IS SAME AS PATIENT

BILLING ADDRESS STREET CITY STATE ZIP CODE

COUNTY RACE LANGUAGE ETHNICITY

MARITAL STATUS PRIMARY CARE PROVIDER

HOME PHONE NUMBER DAY PHONE NUMBER CELL PHONE NUMBER

ALTERNATE PHONE FOR EMERGENCY E-MAIL EMPLOYER

INSURANCE HOLDER ☐ YES ☐ NO

Other Children

NAME ____________ DATE OF BIRTH ____________ MALE ☐ FEMALE ☐

NAME ____________ DATE OF BIRTH ____________ MALE ☐ FEMALE ☐

NAME ____________ DATE OF BIRTH ____________ MALE ☐ FEMALE ☐

SIGNATURE DATE

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Comprehensive Health History

PATIENT FULL LEGAL NAME ______________________ **DATE OF BIRTH** ______________
Home Phone ______________ Cell Phone ______________ Occupation ______________
Marital Status ______________ Work Phone ______________ Employer ______________
Spouse's Legal Name ______________________ Total years of education completed ______
Number of children ______ At home ____ Outside of home ______ Who referred you to our office? ______
What current concerns do you have about your health? ______________________

FEMALES

Date of last pap ______________
Date of last breast exam ______________
Date of last mammogram ______________
Menstrual age onset ___ regular ☐ irregular ☐ pain/cramps ☐
Menopause? ☐ yes ☐ no age ______________
# of pregnancies ___ live births ___ miscarriages ___ abortions ___
Form of birth control ______________

MALES

Date of last prostate exam ______________
Date of last PSA blood test ______________

LEARNING PREFERENCES
What is your learning preference ☐ verbal ☐ written
Do you have any learning barriers? ☐ yes ☐ no
What are those barriers? ______________

PEDIATRIC *(under 18 years old only)*

Birth history ☐ vaginal ☐ c-section ☐ single birth ☐ multiple birth birth order ______
Please indicate any complications during mother's pregnancy or birth ______________
Was your home built prior to 1977? ☐ yes ☐ no How long have you lived in this area? ____

Mother's Name ______________
Phone ______________
Father's Name ______________
Phone ______________

WELLNESS

Date of last colonoscopy ______________
Date of last vision exam ______________
Date of last cholesterol blood test ______________
Was it abnormal or high? ☐ yes ☐ no
Do you have seasonal allergies? ☐ yes ☐ no
Any firearms in the home? ☐ yes ☐ no

Date of last flu vaccine ______ ☐ shot ☐ nasal spray
Date of last Tetanus shot ______________
Do you wear a seatbelt? ☐ yes ☐ no
Do you wear sunscreen? ☐ yes ☐ no
Do you practice safe sex? ☐ yes ☐ no
Do you exercise regularly? ☐ yes ☐ no

Have you ever, or do you:

SMOKE ☐ yes ☐ no Packs per day ______ Year quit ____ Any smokers in the home? ☐ yes ☐ no
SMOKELESS TOBACCO ☐ yes ☐ no ☐ quit How much? ______ Year quit ______
DRINK ALCOHOL ☐ yes ☐ no What forms? ______ Quantity ____ Frequency ______
ILLICIT DRUGS ☐ yes ☐ no What forms? ______ Quantity ____ Frequency ______

ALLERGIES (medication & food)

☐ No known ***medication*** allergies ☐ No known ***food*** allergies

List all medication and food allergies, please identify reaction ______________________

Are you allergic to latex or latex based products? ☐ yes ☐ no ☐ unknown

PATIENT FULL LEGAL NAME ______________________ **DATE OF BIRTH** ______________

PATIENT PAST MEDICAL

- ☐ Allergies
- ☐ Anemia
- ☐ Angina *(chest pain)*
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Atrial fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood clots *location* ______________ *P.E./DVT*______________ *When:* ______________
- ☐ Blood clotting disorder
- ☐ Cancer *location* ______________
- ☐ Cerebrovascular accident *(stroke)*
- ☐ CHF *(Conjestive Heart Failure)*
- ☐ COPD *(Chronic Obstructive Pulmonary Disease)*
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD or chronic heartburn
- ☐ Hepatitis A___ B___ C___
- ☐ Hyperlipidemia *(high cholesterol)*
- ☐ Hypertension *(high blood pressure)*
- ☐ Immune system disorder
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Malignant Hyperthermia
- ☐ Migraine headaches
- ☐ MRSA
- ☐ Myocardial infarction *(heart attack)*
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal *(kidney)* disease
- ☐ Seizure disorder
- ☐ Thyroid *high*___ *low*___ *other*________

Other ____

Have you ever had General Anesthesia? Any complications? ☐ Yes ☐ No

PATIENT PAST SURGICAL

- ☐ Angioplasty *(heart cath)* *year* ____
- ☐ Angio *(heart cath)* w/stent *year* ____
- ☐ Appendectomy *year* ____
- ☐ Arthroscopy knee *year* ____
- ☐ Back surgery *year* ____
- ☐ CABG *(heart bypass)* *year* ____
- ☐ Cardiac stents *year* ____
- ☐ Carpal tunnel release *year* ____
- ☐ Cataract extraction *year* ____
- ☐ Gallbladder surgery *year* ____
- ☐ Colectomy *(colon resection)* *year* ____
- ☐ Colostomy *year* ____
- ☐ Gastric bypass, sleeve *year* ____
- ☐ Hernia repair *year* ____
- ☐ Hip/Knee replacement *year* ____
- ☐ Any Hardware in body *year* ____
- ☐ Lasik *year* ____
- ☐ Liver biopsy *year* ____
- ☐ ORIF *(fracture repair)* *year* ____
- ☐ Pacemaker *year* ____
- ☐ Pacemaker/Difibrillator *year* ____
- ☐ Small bowel resection *year* ____
- ☐ Thyroidectomy *year* ____
- ☐ Tonsillectomy *year* ____

Any Hardware in body ☐ yes ☐ no Type ______________ Location ______________

Other ____

PATIENT PAST SURGICAL – Women only

- ☐ Augmentation mammoplasty *(implants)* *year* ____
- ☐ Bilateral tubal ligation *year* ____
- ☐ Breast Biopsy *year* ____
- ☐ Cesarean Section *year* ____
- ☐ D & C *year* ____
- ☐ Hysterectomy *(abdominal)* *year* ____
- ☐ Hysterectomy *(vaginal)* *year* ____
- ☐ Mastectomy *year* ____
- ☐ Myomectomy *(Fibroidectomy)* *year* ____
- ☐ Reduction mammoplasty *year* ____
- ☐ Oopherectomy *(ovary removal)* *year* ____
- ☐ TAH/BSO *year* ____

Other ____

PATIENT/PARENT/GUARDIAN SIGNATURE ______________________ DATE ______________

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Permission to Disclose Information to Those Involved in My Care

I hereby allow The Excelsior Springs Clinic to disclose the following information
This form does not authorize releasing copies of my medical records.
(check all that apply):

- ☐ Appointment times and dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Tests that have been performed
- ☐ Test results
- ☐ Billing/payment information
- ☐ Other health information (describe)____

To the following people who are involved with my healthcare and/or payment information:
(check all that apply and list names and telephone numbers)

- ☐ Spouse______________________________ Phone:____________________________
- ☐ Friend______________________________Phone:____________________________
- ☐ Child(ren)___________________________ Phone:____________________________
- ☐ Other_______________________________Phone:____________________________

Can confidential messages (i.e. appointment information, prescription information, test results)
be left on your answering machine or voicemail (check how you wish to receive messages)?

- ☐ No, DO NOT leave any messages
- ☐ Yes, at home, cell phone or work
- ☐ Yes, only at home
- ☐ Yes, only on cell phone

Home Phone:______________________
Cell Phone:______________________
Work Phone:______________________

- o I understand that in certain situations The Excelsior Springs Clinic may speak to other individuals who are involved in my care or payment for that care, if permitted by law, that may not be identified on this form.
- o I understand that I have the right to revoke (stop) my permssion at any time.
- o I understand this permission remains in effect until the time I revoke it in writing.

Patient Name (please print):________________________Date:______________

Patient/Guardian Signature:________________________Date:______________

If patient is a minor, please complete the following information:

Mother's name/contact number:____

Father's name/contact number:____

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Patient Name ________________________________ Date of Birth ____________________

Pediatrics

I ____________________________ parent/guardian of ____________________________
hereby give permission for the following individual(s) to pick up prescriptions for my child.
To ensure proper handling of all controlled substances, I understand they/I will be required to show proper photo identification each time.

1. ____
2. ____
3. ____

____
PHARMACY ALLOWED TO PICK UP SCRIPT

Adults

I hereby give permission for the following individual(s) to pick up my prescriptions my absence.
To ensure proper handling of all controlled substances, I understand they/I will be required to show proper photo identification each time.

1. ____
2. ____
3. ____

____
PHARMACY ALLOWED TO PICK UP SCRIPT

☐ No one other than myself (patient) has permission to pick up my prescriptions.

____ ____________________
SIGNATURE DATE

TESC=005

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FINANCIAL POLICY

1. Fees are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we hear from them. As a courtesy, we accept cash, checks, Visa, Discover and Master Card.

2. If you have an HMO or PPO insurance with a designated primary care physician, please make sure you have selected a physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.

3. All co-pays must be paid at the time of your service.

4. **Not all services are a covered benefit in all contracts. If you have a question regarding benefits, you need to call your insurance company prior to your office visit and check your benefits.** Your insurance policy is a contract between you and your insurance company.

5. All services must be paid in full within 30 days after your insurance has paid their portion. If your visit is due to a motor vehicle accident, payment in full is due at the time of the service.

6. The person who brings a child for care is ultimately responsible for their bill. The physician will not get involved in court decisions or support disputes.

7. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full.

8. All returned checks must be paid with cash or money order within five working days or they will be turned over to the prosecuting attorney's office.

9. By submitting your check for payment, you are authorizing the payer, or its agent, upon receipt of your check, to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

10. If you have any questions, please call our office and our billing staff will be glad to assist you.

11. All deductibles and co-payments for obstetric (OB) services must be paid in full by the seventh month with regular payments due each month by cash, check or credit card.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

********* SIGNATURE ON FILE **********

I authorize use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to The Excelsior Springs Clinic. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for all charges whether or not covered by insurance.

PRINT Patient Name____Date of Birth____________________

Signed: ____Date: _________________________________
Patient/Parent/Guardian's Signature