Sky™ HEALTH SERVICES
Phone: (303) 938-1110
Fax: (303) 938-1145

Welcome to Sky Health Services!

Patient Information:

DOB: ____/____/_____

Full Legal Name: _____

Preferred Name (*If different from legal name*): _____

Address:

_____

_____

_____

Cell Phone: (_____) _____-_____

Home Phone: (_____) _____-_____

Email: _____

Would you like access to our online patient portal so you may send and receive **NON-URGENT** medically related messages to your provider?

☐ Yes ☐ No

Preferred Pharmacy Name: _____ Location: _____

Secondary Pharmacy Name: _____ Location: _____

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Billing Information:

Primary Insurance: _____ ID #: _____

Secondary Insurance: _____ ID #: _____

Prescription Insurance: _____ ID #: _____

RxBin: _____ RxPCN: _____ RxGroup: _____

Are you responsible for your own medical bills? ☐ Yes ☐ No

***If no**, please fill out the responsible parties information below*:

Name: _____

Relationship to the patient: _____

Address:

_____

_____

_____

Phone: (_____) _____-_____

Alternate Phone (*if applicable*): (_____) _____-_____

Email: _____

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Voicemails:

Is it OK to leave **DETAILED** voicemails containing medical information?

☐ Yes ☐ No

(***If no**, you will get generic messages requesting a call from our office.)*

Emergency Contacts:

1. Name: _____

Relationship to patient: _____

Phone: (_____) _____-_____

Address:

_____

_____

2. Name: _____

Relationship to patient: _____

Phone: (_____) _____-_____

Address:

_____

_____

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Advanced Directives & Privacy Practices:

Do you have a medical power of attorney? ☐ Yes ☐ No

***If yes**, please fill out the MPOA information below*:

Name: _____

Relationship to patient: _____

Phone: (_____) _____-_____

Alternate Phone (*if applicable*): (_____) _____-_____

Address:

_____

_____

_____

Do you have a Living Will or Advanced Directives? ☐ Yes ☐ No

Do you have a MOST form or DNR? ☐ Yes ☐ No

By signing below, you confirm you have been provided with the Summary or Privacy Practices Notice and you are aware that you may obtain the most recent copy in its entirety in any of our offices or on our website.

Signature: _____ Date: ____/____/_____

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Permission To Share Information

Name: _____

DOB: ____/____/_____

Please review and select one of the following:

☐ Yes, I give permission to Sky Health Services to share my personal medical information with the following people listed should they request information on my behalf.

1. _____
2. _____
3. _____
4. _____
5. _____

☐ No, I do not give permission to Sky Health Services to share my personal medical information with anyone, including family and friends, unless required by law.

Signature: _____ Date: ____/____/_____

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Authorization To Use Or Disclose Protected Health Information

As required by federal privacy regulations, we may not use or disclose your protected health information without your authorization, except as provided in our Notice of Privacy Practices.

Name: _____ DOB: ____/____/_____

I authorize the office of _____ to disclose my protected health information to the office of Sky Health Services for the purpose of establishing care at this practice.

Protected Health Information Authorized to be disclosed includes the following: Lab Reports, Radiology Reports, Diagnosis List, Immunization Records, Health and Maintenance Screening Results, Progress/ Visit Notes and alike.

I understand that once the information has been disclosed by your office, it is no longer under your control. I understand I have the right to:

1. Revoke this authorization by sending a written notice to your office and that revocation will not affect this office's previous reliance on the uses or disclosures pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the protected health information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that whether or not I provide authorization to use or disclose protected health information, it will not condition my treatment, payment or eligibility for benefits.

Signature: _____ Date: ____/____/_____

This authorization remains in effect through _____

This authorization will remain in effect indefinitely unless the date is written above or revoked.

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Financial Waiver

Name: _____

DOB: ____/____/_____

Please review the following and sign below indicating you have read, understand and agree to these policies:

1. Any no-shows or cancellations made within less than 24 hours may be charged a $75 fee per missed visit.

2. All non-covered or self-pay patients will be responsible for full payment upon receiving an invoice.

3. You are responsible for notifying our office of any insurance changes.

4. Invoices are due within 30 days of the statement date. Any payments received after 30 days are subject to a 20% late fee for every month they are late. After 90 days past due, the account may be sent to collections.

5. In the event that you receive a check directly from your insurance company payable to you for services rendered by Sky Health Services, you will be required to endorse this check and promptly deliver it to our office as payment for our services.

Signature: _____ Date: ____/____/_____

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New Patient Medical History:

What is the reason for your visit today?

_____

How much exercise do you get in a typical week?

_____

Briefly describe your eating habits:

_____

Do you have any issues/ concerns with your sleep?

***If yes**, please describe*: _____

Where were you born? _____

Please list your current and/or previous occupations:

_____

Is there anything you would like to tell us?

_____

When was your last colon cancer screening? _____

Was this a stool test or a colonoscopy? _____

When was your last breast cancer screening? _____

Have you been feeling down, hopeless or depressed in the past 2 weeks?

☐ Yes ☐ No

Have you had little interest or pleasure in doing things in the past 2 weeks?

☐ Yes ☐ No

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Past Medical History:

Please disclose any medical conditions you have had and when each started:

Cancer: _____

Diabetes: _____

Heart: _____

Respiratory: _____

Digestive: _____

Endocrine: _____

Brain: _____

Nerves: _____

Urinary: _____

Immune System: _____

Muscular: _____

Skeletal: _____

Other:

_____

_____

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Allergies:

Please list any allergies you have including medications, food and environmental and the severity of the allergy:

_____

_____

_____

_____

_____

_____

Surgical History:

Please list and surgeries, or major hospitalizations, you have had and when they occurred:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Medications and Supplements:

Please list all medications and vitamins/ supplements you are currently taking below ***(please include the dosing and frequency)***:

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Substance Use:

Do you consume caffeine? ☐ Yes ☐ No

***If yes**, how much per week?* _____

Do you drink alcohol? ☐ Yes ☐ No

***If yes**, how many drinks per week?* _____

Are you a previous smoker? ☐ Yes ☐ No

***If yes**, when did you quit?* _____

Do you use tobacco or nicotine currently? ☐ Yes ☐ No

***If yes**, how much per week?* _____

Do you use marijuana/ cannabis products? ☐ Yes ☐ No

***If yes**, what form?* _____

***If yes**, how much per week?* _____

Do you use any recreational/ street drugs? ☐ Yes ☐ No

***If yes**, what?* _____

***If yes**, how much per week?* _____

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Family Medical History:

Please disclose any medical conditions **YOUR FAMILY** has and who had it:

Cancer: _____

Diabetes: _____

Heart: _____

Respiratory: _____

Digestive: _____

Endocrine: _____

Brain: _____

Nerves: _____

Urinary: _____

Immune System: _____

Muscular: _____

Skeletal: _____

Other:

_____

_____

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Fall Risk Assessment

Have you fallen in the past year?

***If yes**, how many times?* _____

***If yes**, what were you doing when you fell?* _____

***If yes**, did you injure yourself?* _____

Can you stand from a chair without using the arms for support?	☐ Yes	☐ No
Can you balance on one leg?	☐ Yes	☐ No
Do you feel steady when walking?	☐ Yes	☐ No
Can you walk without a cane or walker?	☐ Yes	☐ No
Do your shoes fit?	☐ Yes	☐ No
Do you have handrails in your home?	☐ Yes	☐ No
Do you have grab bars in the bathroom?	☐ Yes	☐ No
Do you have a nightlight in your bedroom?	☐ Yes	☐ No
Do you have throw rugs in your home?	☐ Yes	☐ No

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432