Patient Intake Information & Consents

Today's Date: ___________________

A. Patient Information

1. Patient Full Name: ______________________________________ Patient Date of Birth: _____________
   Address: ____ Male ___ Female ___ Age: ________
   city state zip
   Contact Info: hm: ( ) - wk: ( ) - cell: ( ) - e-mail address:________________
   Social Security No.: ______________________ Marital Status: (circle one) single / married / divorced / widowed
   Employer: ____
   name address phone number
   Emergency Contact Name:_____________________Relation to Patient:_______________Phone: ( ) -

   If patient is under the age of 18:
   Responsible Party Full Name: _______________________________ Social Security No.: ___________________
   Date of Birth: __________________________ Relationship to Patient: ___________________________________

2. Insurance Information

Primary Insurance Company Name:

Address:		Phone: ( ) -
ID No.:	Group No.:	
Insured's Name:	Soc. Sec. No.:	DOB:
Insured's Employer (name, city/state/zip):		
Insured's Relationship to Patient:		

Secondary Insurance Company Name:

Address:		Phone: ( ) -
ID No.:	Group No.:	
Insured's Name:	Soc. Sec. No.:	DOB:
Insured's Employer (name, city/state/zip):		
Insured's Relationship to Patient:		

3. Workers' Compensation Injuries

If you are here due to an on-the-job injury, complete the following:

Date of Injury:	Nature of Injury:
Employer Name:	Employer City/State/Zip:
Workers' Compensation Insurance Carrier:	

4. Automobile Injuries

If you are here due to an automobile accident injury, complete the following:

Date of Accident:	
Auto Insurance Carrier:	Policy No.:
Carrier Address (city/state/zip):	

5. General Information

May we leave test results, appointment reminders, and other information on your home answering machine?	Yes ____ No
May we send e-mail with test results, appointment reminders, and other information?	Yes ____ No

List of other providers you are currently seeing: ____
____
____

Name and location of previous primary care physician and address: (name) ________________________________ (city, state) ________________________________	Preferred hospital: ________________________________

Referred by: (circle one)

previous patient
family
friend
doctor

yellow pages
internet
advertisement
other ________________________________

B. Medical History

1. Reason for visit: ____
____.

2. Current Symptoms

Please mark with an (x) any illnesses or medical problems you have now or have had within the past year:

Symptoms	X	Month Started	Symptoms	X	Month Started
Sleep Difficulties			Change in Vision		
Frequent or Severe Headaches			Eyeglasses Needed		
Fainting Spells			Sinus Trouble		
Dizziness on Change of Position			Hay Fever		
Unconscious Spells			Recurrent Sore Throats		
Blurred Vision			Recurrent Mouth Sores		
Earaches			Soreness/Bleeding Gums		
Discharge from Ears			Dentures		
Ringing in Ears			Night Sweats		
Decrease in Hearing			Palpitations/Fluttering of Heart		
Fever					
Recurrent Nose Bleeds			High Blood Pressure		
Strange Taste or Loss in Taste			Swelling of Hands/Feet/Ankles		
Persistent Hoarseness			Leg Cramps While Walking or Reclining		
Difficulty Swallowing			At What Time of Day:		
Enlarged Glands			Enlarged Veins in Legs		
Chest Pain			Nausea or Vomiting		
Angina Pectoris			Shortness of Breath when:		
Coughed up Blood			Walking Several Blocks		
Chronic or Frequent Cough			Ascending a Flight of Stairs		
Chronic or Frequent Cough when Lying Down			Lying Down or Reclining		
Wake up Nights, Short of Breath			Bluish or Purple Lips or Fingers		
			Rectal Pain with Bowel Movement		

Belching or Heartburn Relieved by Food or Medication			Blood in Bowel Movement		
Appetite: Good Fair Poor ?			Full Bladder Feeling but Little Urination		
Abdominal Cramping			Urinate Less than Usual		
Change in Bowel Movement			Pain on Urinating		
Getting up at Night to Urinate?			Difficulty in Starting Urination		
Recurrent Backaches or Pain			Blood in Urine?		
Joint Pain			Discharge from Penis/Vagina		
Swelling of any Joints			Sexual Concerns/Problems?		
Loss or Change in Sensation of Hands or Feet			Tingling or Weakness of Hands or Feet		
Trembling of any Extremity			Redness or Heat in Joints		
Growth in Neck or Throat			Muscle Spasms		
Fatigue Without Obvious Reason			Easy Bruising		
Inability to Tolerate Cold			Inability to Tolerate Heat		

Stress? Yes No If Yes, list cause(s): ______________________________

Allergies? Yes No If Yes, list: ______________________________
____
____

4. Past Medical History

Please circle any illnesses or medical problems you have now or have had in the past and indicate the year each started; if this has occurred within the last three years, add an asterisk (*):

Illness	**Year**	**Illness**	**Year**	**Illness**	**Year**	**Illness**	**Year**
Polio		Rheumatic fever / heart disease		Nephritis		Meningitis	
Bursitis/sciatica/lumbago		Bladder disorder		Influenza		Neuritis / neuralgia	
Arthritis		Rheumatism		Pleurisy		Joint disease	
Gonorrhea		Bone disease		Tuberculosis		Jaundice	
Gallbladder disease		Anemia		Diabetes		Migraine headaches	
Syphilis		Colitis		Bowel disease		Epilepsy	
HIV positive		Hemorrhoids		Cancer		AIDS	
Frequent infection		Asthma		Panic attacks		Nervous breakdown	
Depression		Psychosis		Schizophrenia		Bi-Polar Disorder	

5. For Women Only

Onset of Menarche (First Menstrual Period)		Date of Last Menstrual Period	
Date of Last PAP Smear		Date of Last Mammogram	
Number of Pregnancies		Number of Live Births	
Date of First Pregnancy			
Vaginal Discharge	Yes No	Using Oral Contraceptives	Yes No

6. Weight History

Recent Weight Loss	Yes No Amount:	Recent Weight Gain	Yes No Amount:

7. Medication and Substance Use

	Never	Past	Occasionally	Frequently	Daily	**If Current, list below with *Current Medications/Supplements***
Laxatives						
Tranquilizers/Sedatives						
Sleeping Pills						
Appetite Depressants						
Street Drugs						
Tobacco						
Alcohol						
Advil/Tylenol						
Aspirin						

8. Hospitalizations

List all hospitalizations, operations, tests, procedures, and severe injuries:

Date	Type of Operation, Test, Procedure, Severe Injury	Physician and Medical Facility

9. Recent Diagnostic Tests

Specify	CAT SCANS X-Rays: Date(s)	PET SCANS Bone Scans: Date(s)	Ultrasound: Date(s)	MRI Date(s)	Medical Facility
Additional Studies:					
Have you ever been advised to have a test, procedure, or surgery, but decided against it? Yes No If Yes, explain:					

10. Recent Procedures

Have you had a recent procedure (e.g. colonoscopy, endoscopy, etc.) in the last three years? Yes No

Date of the Procedure: ______________________________

Type of Procedure: ______________________________

Facility Procedure was Performed at: ______________________________

11. Family History

Has any blood relative ever experienced cancer, blood disorders, heart disease, high blood pressure, or diabetes?	Yes No If Yes, explain: ______________________________ ______________________________ ______________________________

Immediate Family Health	Age	Present Health	Deceased?	Age at Death	Year of Death	Cause of Death
Father						
Mother						
Brother Sister						
Brother Sister						
Brother Sister						
Brother Sister						
Brother Sister						
Husband / Wife						
Children and their Name						

12. Current Medications / Supplements

List all medications, vitamins, or supplements you are now taking, including those you buy with/without a doctor's prescription:

Name	Dosage	Times per Day	Reason

Hormones (specify: thyroid, estrogen, testosterone, etc.)? Yes No
If Yes, for what?

Steroids (specify: cortisone, ACTH, etc.)? Yes No
If Yes, for what?

13. Complementary and Alternative Therapies

Have you ever been treated with any complementary and/or alternative therapies
(e.g. acupuncture, massage therapy, chiropractic, etc.)? Yes No
If Yes, please list: ______________________________
____
____

Have you stopped any of these therapies? Yes No
If Yes, please list reason(s) why:
____
____
____

Patient Consents

Patient Full Name: ____ Patient Date of Birth: _______________

I agree my health information may be used to assist with my treatment, seek payment for health care services and products, and in routine practice operations, and I have received this office's Notice of Privacy Practices. _______

I agree Azalea Family Health Care, LLC may furnish my insurance companies with all information they request concerning my treatment, including all of my personal health information. _______

I assign to Azalea Family Health Care, LLC all payments I become entitled to receive for services and products provided to me by Azalea Family Health Care, LLC. _______

I understand I must pay all co-payments, deductibles, and other charges not covered by insurance companies or other benefit programs. I understand that if these benefits stop for any reason, I must pay for all services and products provided. _______

I agree to pay for services and products provided if for any reason insurance companies and other benefit plans do not pay. If I do not provide complete and correct insurance information, I may have to pay charges that would otherwise be covered by insurance. If my insurance requires a referral, and I do not have the necessary referral I will be responsible for paying for all services and products provided. If I file a Workers' Compensation claim, I authorize Azalea Family Health Care, LLC to release my personal health information, including information about my condition and treatments, to the Workers' Compensation insurance company, my employer, and my lawyer. I understand I may request a copy of my own health information, propose changes or additions, and receive a list of non-treatment related disclosures of the information. _______

I understand this office participates in the DCIPA Community Health Record System. This means Azalea Family Health Care LLC will enter my health information, including chart notes, prescription records, operatory notes, radiographs and scans, lab results, and other health information in a secure shared database accessible only to other participating community healthcare providers. My other medical providers participating in the shared database do the same thing, permitting all participating providers ready access to up to date information regarding my condition and care. Participating in this shared database allows my healthcare providers to provide me better care with less hassle. By signing below, I agree Azalea Family Health Care LLC may include my health information in the database, view all of my personal health information on the database, and share my personal health information with other participating providers through the database. I understand that, with certain exceptions, if I refuse to permit my health information to be included in this shared database, Azalea Family Health Care LLC may refuse to treat me. _______

I agree Azalea Family Health Care LLC may from time to time take photographs of me and keep them with my medical records. I agree that all my medical providers may use these photographs for identification purposes, to prevent fraud, and to assist with my medical care. _______

Patient Name: ____
Patient Signature: ____ Date: __________________________

If patient is under the age of 18, or unable to read or understand the above, this form must be signed by a competent adult responsible for the care of the patient. The responsible adult assumes all obligations above.

Responsible Adult: ____
Relationship to Patient: ____
Signature: ____ Date: __________________________