***Patient Intake Form***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Name: | | |  | | | | | | | | | | | | | | | | | | | | | | Date of birth | | | | | | | | |  | | | | | | | | | |
|  | | |  | | | | |  | | | |  | | | |  | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | |
| **DO YOU HAVE A PACEMAKER OR ICD?**  **(Implantable Cardiac Device)** | | | | | | | | | | | | | | | | | | | |  | |  |  | **YES** | | | | | | | | | **NO** | | | | | | | | |
| Medication Allergies | | | | | | | | YES | | | | NO | | | |  | | | | | |  | | | | | | | |  | | | | | | | | | | |  | | |
| If yes please list the medications and reactions: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Food Allergies | | | | | | | | YES | | | | NO | | | | Please list: | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Latex Allery: | | | | | | | | YES | | | | NO | | | |  | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | |
|  | | |  | | | | |  | | | |  | | | |  | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | |
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| **List all medications (include vitamins and supplements) if more please bring in a list** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  |  | | | | | | |  | | | | | | | | |  | |  | | | | | | | |
| DRUG | | | | | | | | | | | | | | |  | | DOSE | | | | | | | | |  | FREQUENCY | | | | | | | | | | | | | | | | |
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| **Have you ever had a colonoscopy YES NO If yes When and with who** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Do you take Aspirin? | | | | | | | | | YES | | NO | | |  | | | | | Do you take Ibuprofen/Motrin? | | | | | | | | | | | | | | | | | | | | | YES | | | NO |
| If yes: | | | |  | | | | | | | |  | | | | | | |  | | | If yes: | | | | | | |  | | | | | | | | | | | |  | | |
|  | | | | Dose: | | | | | |  | | | | | | | | |  | | |  | | | | | | | Dose: | | | | | | | | |  | | | | | |
|  | | | | Frequency: | | | | | |  | | | | | | | | |  | | |  | | | | | | | Frequency: | | | | | | | | |  | | | | | |
|  | | | |  | | | | | | | |  | | | | | | |  | | |  | | | | | | | | |  | | | | | | | | | |  | | |
| Last Flu Vaccination | | | | | |  | | | | | | | Month/yr. | | | | | |  | | | Do you smoke? | | | | | | | | | YES NO | | | | | | | | | | | | |
| Pneumonia Vaccination | | | | | | | |  | | | | | Month/yr. | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | |  | | | | | | |  | | | | | | | | How many times day? | | | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | How many years? | | | | | | | | | | | | |  | | | | | | | | |
| Last Mammogram | | | | | |  | | | | | | | Month/yr. | | | | | |  | | |  | | | | | | |  | | | | | | | | | | | | | | |
| Last Pap exam | | | | |  | | | | | | | | Month/yr. | | | | | |  | | | Have you ever smoked? | | | | | | | | | | | | | | | | YES NO | | | | | |
|  |  | | | | | | |  | | | |  | | | | | | |  | | | When did you quit? (What year) | | | | | | | | | | | | | | | | | |  | | | |
| Height: |  | | | | | | | Weight: | | | |  | | | | | | |  | | |  | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  |  | | | | | | |  | | | | | | | | |  | |  | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | |  |  | | | | | | |  | | | | | | | | |  | |  | | | | | |  | |
| Do you use any other substances? | | | | | | | | | | | YES NO | | | | | | | |  | | | Do you use Alcohol? | | | | | | | | | | | | | | YES NO | | | | | | | |
| If yes what? | |  | | | | | | | | | | | | | | | | |  | | |  | How many times day? | | | | | | | | | | | | | | |  | | | | | |  | |
| How often do you use? | | | | | | | |  | | | | | | | | | | |  | | |  | How many years? | | | | | | | | | | |  | | | | | | | | | |  | |  | |

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***Patient Registration and Consent for Treatment Form***

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_ EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have an implantable cardiac device? YES NO**

Pace Maker **OR**  Implantable defibrillator

If yes – Please bring your information card for your chart.

The following questions are required to ask as part of the meaningful use insurance requirements:

**Do you have a medical power of attorney, living will, or advance directive? □ YES □NO □ I don’t know**

If you have one of the above, please bring a copy for your file here. If you have questions about a medical power of

attorney, living will, or advance directive, please ask your provider during your appointment.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Race: | |  | | | | | |  | Primary Language | | | | | |  | | | |
| Ethnicity (select one) | | | | | | |  | |  | | |  | | | | |  |  |
| □ | Spanish/ Hispanic Origin | | | | | |  | | □ | | Not of Spanish / Hispanic Origin | | | | | | | |
| □ | Pt declined/unknown | | | | | |  | | □ | | OTHER | | | | | |  |  |
|  | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | |  | | | | | |
| Emergency Contact & Phone number: | | | |  | | | | | Relationship | | | |  | | | | | |
| Pharmacy Name: | | |  | | | | | | Pharmacy Location: | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Primary Care Physician: | | | | | |  | | | | |  | | | | | | | |
| Referring Provider: | | | | | |  | | | | | | | | |  | | | | |
| Specialty Providers (Urologist/Gastroenterologist/Cardiologist) | | | | | |  | | | | | | | | |  | | | | |
| OBGYN Provider: | | | | | |  | | | | |  | | | | | | | |
|  | | | | | |  | | | | |  | | | | | | | |
| **It is very important to us to understand how you learned about our practice (please circle all that apply)** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Primary Care Physician | | | | |  | Emergency Rm | | |  | Website | | | |  | | Phone book | | |
| Urology | | | | |  | Urgent Care | | |  | Newspaper | | | |  | | TV Advertisement | | |
| GYN/OB | | | | |  | VA Hospital | | |  | Cancer Services | | | |  | | Radio Advertisement | | |
| GI/Gastroenterology | | | | |  | Friend or Family Member | | |  | Facebook | | | |  | | Twitter | | |
|  | | | | |  |  | | |  |  | | | |  | |  | | |
|  | | | | |  | OTHER: | | | | | | | | | | | | |

**Would you like to be announced by a pro-noun? YES NO**

**If YES (please circle) : HE SHE THEY WE OTHER**











