Patient Intake Form

Step 1 of 4 • Patient Information

Complete all required fields marked with *.

Patient Information

Personal details

Last Name *

First Name *

Middle Name

Date of Birth *

Social Security #

Home Phone

Cell Phone

Address

Where do you live?

Mailing Address *

City *

State *

ZIP Code

Email *

Race

Preferred Language

Personal & Status

Select what applies

Male

Female

Marital Status

Employment Status

Pharmacy Information

Your preferred pharmacies

Local Pharmacy & Location

Mail Order Pharmacy

Physicians

Your care team

Referring Physician & Phone #

Primary Care Physician & Phone #

Emergency Contact

In case of emergency

Emergency Contact Name

Phone #

Relationship

Insurance Information

Your insurance details

HIPAA Information & Consent

Step 4 of 4 • Consent & Authorization

Please read the information below before signing.

HIPAA Information and Consent Form

The Health Insurance and Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a “short” version. A full version is posted in the office, and is available upon request. There are rules and restrictions on who may have access to your Protected Health Information (PHI). HIPAA provides certain rights and protections to you as the patient.

As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided in our office, but also disclosures of your health information may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment, or submission of claims to third party payers or insurers for claims review, determination of benefits or payment described in our Notice of Privacy Practices.

We may call patients in the waiting room when it is time for them to go to an examining room. To do this, we may use your first and/or last name.

It is the policy of this office to remind patients of their appointments. We may have to contact you to provide appointment reminders or to have you contact the office. To do this, we may mail you letters in envelopes with our practice name and return address, call you at your home or work, or leave messages with family members or voicemail.

You have the right to request restriction in the use of your protected health information and to request change in certain policies within the office concerning your PHI. You must request restrictions in writing. However, we are not obligated to alter internal policies to conform to your request.

By signing this consent you signify that you agree that all payments are deemed your responsibility and are due at the time of service unless prior arrangement has been made, or you have insurance coverage for which you have provided copies for filing purposes.

My signature on this form will serve as “SIGNATURE ON FILE” for processing any applicable insurance claims. I understand that my insurance may deny benefits if I received an examination too frequently or received examinations by separate doctors for the same illness. I agree to pay for services that my insurance deems my responsibility.

I agree to pay my Copay, co-insurance, and/or deductible at the time of services rendered. I also understand that all costs are estimated and that the insurance will make the final determination of the amount that I am responsible for.

By signing this consent, you signify that you agree that we can, will use, and disclose your health information to treat and to obtain payment for our services rendered to you. We may decline treatment should you refuse to sign this consent.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Electronic Consent

I have read and understand the HIPAA information and consent above.

Patient Signature / Typed Name *

Date *

For questions about privacy or this consent, please contact the practice office.

Health History Questionnaire

Step 2 of 4 • Symptoms & Diagnoses

Patient Name

Date

Current Symptoms

Check all that apply

- Change in appetite
- Weight loss
- Nausea
- Vomiting
- Trouble swallowing
- Heartburn
- Abdominal pain
- Vomiting Blood
- Black tarry stools
- Diarrhea
- Jaundice
- Constipation
- Changes in bowel habits

Weight loss — How Much

Over what period of time

Other

Diagnosed Medical Conditions

Check all that apply

- Hepatitis
- Seizures
- Stroke
- Anxiety/Depression
- Nervousness/Panic attacks
- Ulcers
- Colitis
- Colon polyps
- Diverticulosis/Diverticulitis
- Crohn's Disease
- Spastic Colon
- Gerd
- Celiac Disease
- Barrett's
- Colon Cancer
- Gallstones
- Excessive scar tissue/Adhesions
- Cancer
- High Blood Pressure
- High Cholesterol
- Congestive heart failure
- Heart Attack
- Irregular heartbeat
- Valvular heart disease
- Emphysema
- Asthma
- Sinus trouble
- Allergies
- Bronchitis
- Pneumonia
- Blood clot in lung
- Thyroid problems
- Diabetes
- Poor circulation
- Blood clot in leg
- Arthritis
- Genital disorders
- Prostate problems
- Pelvic infections

Other Medical Problems

Surgical History & Lifestyle

Step 3 of 4 • Operations & Lifestyle

Patient Name

Date

Previous Operations

Check all that apply

- Removal of part / all of stomach
- Removal of part / all of colon
- Removal of gallbladder
- Removal of appendix
- Removal of spleen
- Hemorrhoid surgery
- Hernia surgery
- Replacement of heart valve
- Heart Bypass
- Heart Catheterization
- “Roto-Rooter” of blood vessels
- Artificial blood vessel graft
- Prostate surgery
- Hysterectomy
- Tubaligation
- Removal of kidney
- Placement of artificial joint
- Tonsillectomy
- Eye surgery
- Knee Replacement

Other surgeries

Tobacco Use

- Never Smoker
- Former Smoker
- Current Smoker
- Chewing Tobacco
- Snuff

Caffeine Use

- Coffee
- Tea
- Carbonated Beverages
- No Caffeine Use

Alcohol Use

- Occasional
- Moderate
- Heavy
- Beer
- Wine
- Hard Liquor

Drug use

Medications

Medication • Mg • How Often

Family History & Current Symptoms

Additional Health Information

Patient Name

Date

Family History of Medical Problems

Enter affected family member(s)

Mother (1) Father (2) Sister (3) Brother (4) Mother's Mother (5) Mother's Father (6) Father's Mother (7) Father's Father (8)

Colitis

Crohn's disease

Hypertension

Celiac disease

Gastric cancer

High Cholesterol

Esophageal cancer

Liver cancer

Heart disease

Pancreatic cancer

Stomach cancer

Lung disease

Colon cancer

Diabetes

Other

Current Symptoms

Check all that apply

Chills	Voice Changes	Back Pain
Fatigue	Swollen Glands	Joint Pain
Fever	Chronic Cough	Dizziness
Night Sweats	Chest Pain	Headaches
Itchy Skin	Shortness of Breath	Cold/Heat Intolerance
Blurred Vision	Swelling of Extremities	Excessive Thirst
Choking Sensation	Belching	Easy Bruising
Hoarseness	Bloating	
Sore Throat	Chronic Diarrhea	

Additional Notes

Anything else you would like your care team to know