

NEW PATIENT INTAKE FORM

Last Name		First Name		Middle Name		Nickname	
Social Security		Birth Date		Age			
Birth Sex	Current Gender		Gender Identity		Sexual Orientation		Preferred Pronoun
<input type="checkbox"/> Female	<input type="checkbox"/> Female		<input type="checkbox"/> Female		<input type="checkbox"/> Straight or heterosexual		
<input type="checkbox"/> Male	<input type="checkbox"/> Male		<input type="checkbox"/> Male		<input type="checkbox"/> Choose not to disclose		
	<input type="checkbox"/> Choose not to disclose		<input type="checkbox"/> Choose not to disclose		<input type="checkbox"/> Bisexual		
	<input type="checkbox"/> Other		<input type="checkbox"/> Additional gender category or other, please specify:		<input type="checkbox"/> Lesbian, gay or homosexual		
					<input type="checkbox"/> Don't Know		
					<input type="checkbox"/> Something else, please describe:		

Contact Information

1. <input type="checkbox"/> Primary Address <input type="checkbox"/> Secondary Address								
Street 1		Street 2		Address Type	City		State	Zip
				<input type="checkbox"/> Home				
				<input type="checkbox"/> Mailing				
2. <input type="checkbox"/> Primary Address <input type="checkbox"/> Secondary Address								
Street 1		Street 2		Address Type	City		State	Zip
				<input type="checkbox"/> Home				
				<input type="checkbox"/> Mailing				
Home Phone			Day Phone			Cell Phone		E-Mail
In Case of Emergency Notify				Relationship			Emergency Contact Phone	

Insurance Information - Please Give Your Insurance Cards To Receptionist For Scanning

Primary Insurance	ID #	Group #
Primary Insurance - Claims Billing Address		
Insured Person's Name		Birth Date
Secondary Insurance	ID #	Group #
Secondary Insurance - Claims Billing Address		
Insured Person's Name		Birth Date
Employer	Occupation	Employer Phone #
Pharmacy Name #1	Cross Streets OR Address	Phone #
Pharmacy Name #2	Cross Streets OR Address	Phone #

Demographics

Race		Ethnicity		Preferred Language			
<input type="checkbox"/>	Asian	<input type="checkbox"/>	White	<input type="checkbox"/>	Unknown	<input type="checkbox"/>	English
<input type="checkbox"/>	Black or African American	<input type="checkbox"/>	Other	<input type="checkbox"/>	Declined to specify	<input type="checkbox"/>	Spanish
<input type="checkbox"/>	Declined to specify	<input type="checkbox"/>		<input type="checkbox"/>	Hispanic or Latino	<input type="checkbox"/>	Other
<input type="checkbox"/>	Hispanic Or Latino (All Races)	<input type="checkbox"/>		<input type="checkbox"/>	Not Hispanic or Latino	<input type="checkbox"/>	
<input type="checkbox"/>	Indian	<input type="checkbox"/>		<input type="checkbox"/>	Other	<input type="checkbox"/>	
<input type="checkbox"/>	Multi-racial	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Native American Indian	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Primary Care Provider

Referring Provider

Medical - Do you have any of the following? (Please check all that apply):

	Date Diagnosed		Date Diagnosed		Date Diagnosed		
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Diabetes Type	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px; text-align: center;">1</td><td style="width: 20px; height: 20px; text-align: center;">2</td></tr></table>	1	2	<input type="checkbox"/> Peptic Ulcer Disease	_____
1	2						
<input type="checkbox"/> Alzheimer's Disease	_____	<input type="checkbox"/> Dialysis	_____	<input type="checkbox"/> Peripheral Vascular Disease	_____		
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Drug Use/Substance Dependency	_____	<input type="checkbox"/> Psoriasis	_____		
<input type="checkbox"/> Anesthesia Reaction	_____	<input type="checkbox"/> Elevated Lipids Other:	_____	<input type="checkbox"/> Pulmonary Embolism	_____		
<input type="checkbox"/> Angina(Chest Pain)	_____	<input type="checkbox"/> Endocarditis	_____	<input type="checkbox"/> Pulmonary Fibrosis	_____		
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Fibromyalgia	_____	<input type="checkbox"/> Renal/Kidney Disease Type:	_____		
<input type="checkbox"/> Arthritis Type:	_____	<input type="checkbox"/> Gallbladder Disease	_____	<input type="checkbox"/> Scoliosis	_____		
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> GERD/Reflux	_____	<input type="checkbox"/> Seizure Disorder	_____		
<input type="checkbox"/> Bleeding Disorder	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Sleep Apnea	_____		
<input type="checkbox"/> Blood Clots	_____	<input type="checkbox"/> Headache, Migraine	_____	<input type="checkbox"/> Spinal Stenosis	_____		
<input type="checkbox"/> Cancer Type:	_____	<input type="checkbox"/> Hepatitis/Liver Disease	_____	<input type="checkbox"/> Spondyloarthropathy (Joint Disease of the Vertebral Column)	_____		
<input type="checkbox"/> Cardiac Arrhythmia (Irregular Heart Beat)	_____	<input type="checkbox"/> HIV/Aids	_____	<input type="checkbox"/> Stroke	_____		
<input type="checkbox"/> Complex Regional Pain Disorder	_____	<input type="checkbox"/> Hypertension (High Blood Pressure)	_____	<input type="checkbox"/> Systemic Lupus Erythematosus	_____		
<input type="checkbox"/> Congestive Heart Failure	_____	<input type="checkbox"/> Inflammatory Bowel Disease	_____	<input type="checkbox"/> Thyroid Disease	_____		
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	_____	<input type="checkbox"/> Lyme Disease	_____	<input type="checkbox"/> Varicose Veins	_____		
<input type="checkbox"/> Coronary Artery Disease	_____	<input type="checkbox"/> Malignant Hyperthermia	_____	<input type="checkbox"/> Valvular Disease (Heart Valve Problems)	_____		
<input type="checkbox"/> Crohn's Disease	_____	<input type="checkbox"/> MRSA	_____	<input type="checkbox"/> Vancomycin-Resistant Enterococci	_____		
<input type="checkbox"/> Degenerative Joint Disease (Osteoarthritis)	_____	<input type="checkbox"/> Myocardial Infarction (Heart Attack)	_____	<input type="checkbox"/> Other	_____		
<input type="checkbox"/> Dementia	_____	<input type="checkbox"/> Obesity	_____	_____	_____		
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Osteoporosis	_____	_____	_____		
<input type="checkbox"/> Dermatitis	_____	<input type="checkbox"/> Parkinson Disease	_____	_____	_____		

Surgical - Do you have or have you had any of the following? (Please check all that apply):

	Date		Date		Date				
<input type="checkbox"/> ACL Repair	_____	<input type="checkbox"/> Cholecystectomy	_____	<input type="checkbox"/> Organ Transplant Specify:	_____				
<input type="checkbox"/> Amputation	_____	<input type="checkbox"/> Colectomy	_____	<input type="checkbox"/> ORIF Site: (Surgery for Fracture)	_____				
<input type="checkbox"/> Angioplasty	_____	<input type="checkbox"/> Colostomy	_____	<input type="checkbox"/> Radiation Therapy	_____				
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Gender Reassignment	_____	<input type="checkbox"/> Rotator Cuff Repair	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R								
<input type="checkbox"/> Arthroscopy Site:	_____	<input type="checkbox"/> Hemorrhoidectomy	_____	<input type="checkbox"/> Shoulder Replacement	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R								
<input type="checkbox"/> Back Surgery	_____	<input type="checkbox"/> Hernia Repair	_____	<input type="checkbox"/> Small Bowel Resection	_____				
<input type="checkbox"/> Bariatric/Gastric Bypass	_____	<input type="checkbox"/> Hip Replacement	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	<input type="checkbox"/> Stents in Heart	_____		
L	R								
<input type="checkbox"/> Blood Transfusion	_____	<input type="checkbox"/> Hip Replacement Revision	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	<input type="checkbox"/> Stents Other Body Part Specify:	_____		
L	R								
<input type="checkbox"/> Breast Augmentation	_____	<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Thyroidectomy	_____				
<input type="checkbox"/> Breast Biopsy	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	<input type="checkbox"/> Knee Replacement	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	<input type="checkbox"/> Tonsillectomy	_____
L	R								
L	R								
<input type="checkbox"/> CABG/ Heart Bypass	_____	<input type="checkbox"/> Knee Replacement Revision	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	<input type="checkbox"/> Other	_____		
L	R								
<input type="checkbox"/> Cardiac Pacemaker	_____	<input type="checkbox"/> Lasik	_____	_____	_____				
<input type="checkbox"/> Cardiac Valve Replacement	_____	<input type="checkbox"/> Liver Biopsy	_____	_____	_____				
<input type="checkbox"/> Carpal Tunnel Release	_____	<input type="checkbox"/> Mastectomy	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	_____	_____		
L	R								
<input type="checkbox"/> Cataract Extraction	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	<input type="checkbox"/> Meniscus Surgery Site:	_____	_____	_____		
L	R								
<input type="checkbox"/> Cesarean Section	_____	<input type="checkbox"/> Nephrectomy	_____	_____	_____				

Social

Tobacco Use

Have you ever used tobacco? No Yes Former

Tobacco type:	Daily Use?		How many/much per day:	Age started:	Age stopped:
	Yes	No			
<input type="checkbox"/> Cigarette					
<input type="checkbox"/> Cigarillo					
<input type="checkbox"/> Cigar Pipe					
<input type="checkbox"/> Chewing					
<input type="checkbox"/> Smokeless					
<input type="checkbox"/> Snuff					
<input type="checkbox"/>					

Vaping Use

Vaping use? Yes No

Status: Current user Not a current user Vaping without Nicotine

Duration: Age started: Age stopped:

Alcohol:

Do you drink alcohol? No Yes Formerly Frequency:

Family History

No family history of:

Unknown

Relationship: B = Brother, F = Father, M = Mother, S = Sister

	Relationship:	Relationship:				Onset age:	Cause of death:		Relationship:	Relationship:				Onset age:	Cause of death:
		B	F	M	S					B	F	M	S		
<input type="checkbox"/> ADD/ADHD								<input type="checkbox"/> Genetic Disease							
<input type="checkbox"/> Alcoholism								<input type="checkbox"/> Gout							
<input type="checkbox"/> Allergies								<input type="checkbox"/> Hearing Impairment							
<input type="checkbox"/> Alzheimer's Disease								<input type="checkbox"/> Hypertension							
<input type="checkbox"/> Anemia								<input type="checkbox"/> Irritable Bowel Syndrome							
<input type="checkbox"/> Arthritis								<input type="checkbox"/> Learning Disability							
<input type="checkbox"/> Asthma								<input type="checkbox"/> Liver Disease							
<input type="checkbox"/> Blood Disorder								<input type="checkbox"/> Mental Illness							
<input type="checkbox"/> Cancer								<input type="checkbox"/> Migraines							
<input type="checkbox"/> Cardiovascular Disease								<input type="checkbox"/> Muscle Disease							
<input type="checkbox"/> Cholelithiasis								<input type="checkbox"/> Obesity							
<input type="checkbox"/> Colitis								<input type="checkbox"/> Osteoporosis Congenital							
<input type="checkbox"/> Heart Disease								<input type="checkbox"/> Parkinson's Disease							
<input type="checkbox"/> Congestive Heart Failure								<input type="checkbox"/> Peripheral Vascular Disease							
<input type="checkbox"/> COPD								<input type="checkbox"/> Renal Disease/Kidney Disease							
<input type="checkbox"/> Coronary Artery Disease								<input type="checkbox"/> Seizure Disorder							
<input type="checkbox"/> Coronary Artery Disease, Premature								<input type="checkbox"/> Stroke							
<input type="checkbox"/> Depression								<input type="checkbox"/> Thyroid Disorder							
<input type="checkbox"/> Developmental Delay								<input type="checkbox"/> Other							
<input type="checkbox"/> Diabetes Drug Abuse															
<input type="checkbox"/> Eczema															
<input type="checkbox"/> Elevated Lipids															
<input type="checkbox"/>															

Medication

	Name of Drug	Strength	Dose Per Day	Reason Prescribed
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Allergies - Please check all that apply:

<input type="checkbox"/>	Accupril (Quinapril)	<input type="checkbox"/>	Diamox	<input type="checkbox"/>	Metal/Nickel	<input type="checkbox"/>	Tape/Adhesives
<input type="checkbox"/>	Acetaminophen	<input type="checkbox"/>	Dicloxacillin	<input type="checkbox"/>	Micronase (Glyburide)	<input type="checkbox"/>	Tegretol (Carbamazepine)
<input type="checkbox"/>	Acyclovir	<input type="checkbox"/>	Doxycycline	<input type="checkbox"/>	Minocin (Minocycline)	<input type="checkbox"/>	Tenormin (Atenolol)
<input type="checkbox"/>	Advil (Ibuprofen)	<input type="checkbox"/>	Egg	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	Tetanus toxoid
<input type="checkbox"/>	Altace (Ramipril)	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	Motrin (Ibuprofen)	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	Ampicillin	<input type="checkbox"/>	Famotidine	<input type="checkbox"/>	Naprosyn (Naproxen)	<input type="checkbox"/>	Ticlid
<input type="checkbox"/>	Amaryl (Glimepiride)	<input type="checkbox"/>	Flagyl	<input type="checkbox"/>	Neptazane	<input type="checkbox"/>	Valium (Diazepam)
<input type="checkbox"/>	Augmentin (Amoxicillin)	<input type="checkbox"/>	Floxin	<input type="checkbox"/>	Niacin	<input type="checkbox"/>	Vancomycin
<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Glucotrol (Glipizide)	<input type="checkbox"/>	Oxycodone	<input type="checkbox"/>	Vasotec
<input type="checkbox"/>	Bactrim (Sulfamethoxazole)	<input type="checkbox"/>	Heparin	<input type="checkbox"/>	Peanut	<input type="checkbox"/>	Zestril
<input type="checkbox"/>	Biaxin	<input type="checkbox"/>	Ibuprofen	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Zithromax
<input type="checkbox"/>	Carafate (Sucralfate)	<input type="checkbox"/>	Inderal (Propranolol)	<input type="checkbox"/>	Percocet (Oxycodone)	<input type="checkbox"/>	Zocor (Simvastatin)
<input type="checkbox"/>	Ceclor (Cefaclor)	<input type="checkbox"/>	Indocin (Indomethacin)	<input type="checkbox"/>	Persantine	<input type="checkbox"/>	Zyloprim (Allopurinol)
<input type="checkbox"/>	Celebrex	<input type="checkbox"/>	Insulin (Animal)	<input type="checkbox"/>	Plavix	<input type="checkbox"/>	Other (i.e. Food, Environmental)
<input type="checkbox"/>	Cephalosporins	<input type="checkbox"/>	Iodine or Shellfish	<input type="checkbox"/>	Phenytoin		
<input type="checkbox"/>	Cipro (Ciprofloxacin)	<input type="checkbox"/>	Keflex (Cephalexin)	<input type="checkbox"/>	Pravachol		
<input type="checkbox"/>	Clinoril (Sulindac)	<input type="checkbox"/>	Klonopin	<input type="checkbox"/>	Prevacid		
<input type="checkbox"/>	Contrast Media (Ioversol)	<input type="checkbox"/>	Lasix (Furosemide)	<input type="checkbox"/>	Prilosec		
<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Prinivil		
<input type="checkbox"/>	Coumadin	<input type="checkbox"/>	Levofloxacin	<input type="checkbox"/>	Quinolones		
<input type="checkbox"/>	Darvon	<input type="checkbox"/>	Lidocaine	<input type="checkbox"/>	Ranitidine		
<input type="checkbox"/>	Demerol	<input type="checkbox"/>	Lipitor	<input type="checkbox"/>	Septra (Sulfamethoxazole)		
<input type="checkbox"/>	Depakote	<input type="checkbox"/>	Lodine	<input type="checkbox"/>	Sulfa		
<input type="checkbox"/>	DiaBeta (Glyburide)	<input type="checkbox"/>	Lopressor (Metoprolol)	<input type="checkbox"/>	Tagamet (Cimetidine)		

Review of Systems - Do you experience any of the following:

Constitutional

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Malaise
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss

Other: _____

HEENT

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Ear Drainage
<input type="checkbox"/>	<input type="checkbox"/>	Ear Pain
<input type="checkbox"/>	<input type="checkbox"/>	Eye Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	<input type="checkbox"/>	Nasal Drainage
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	<input type="checkbox"/>	Visual Changes

Other: _____

Cardiovascular

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Claudication (Leg Cramps)
<input type="checkbox"/>	<input type="checkbox"/>	Edema/Swelling
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Raynaud's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Tests or procedure on arteries or veins in legs

Other: _____

Gastrointestinal

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stools
<input type="checkbox"/>	<input type="checkbox"/>	Change in Stools
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting

Other: _____

Neurological

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Extremity Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Extremity Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Gait Disturbance
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Memory Impairment
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tremors

Other: _____

Integumentary

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Breast discharge
<input type="checkbox"/>	<input type="checkbox"/>	Breast lump
<input type="checkbox"/>	<input type="checkbox"/>	Brittle hair
<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails
<input type="checkbox"/>	<input type="checkbox"/>	Hair loss
<input type="checkbox"/>	<input type="checkbox"/>	Hirsutism (excessive body hair)
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Pruritus (Itching)
<input type="checkbox"/>	<input type="checkbox"/>	Mole changes
<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Skin lesion

Other: _____

Respiratory

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Known TB Exposure
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing

Other: _____

Psychiatric

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia

Other: _____

Metabolic/Endocrine

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Polydipsia (Excessive Thirst)
<input type="checkbox"/>	<input type="checkbox"/>	Polyphagia (Excessive Hunger)

Other: _____

Musculoskeletal

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain

Other: _____

Hematologic/Lymphatic

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising
<input type="checkbox"/>	<input type="checkbox"/>	Lymphadenopathy (Lymph Node Disease)

Other: _____

Immunologic

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Contact Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Environmental Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies

Other: _____

Colonoscopy

Yes No Date: _____

Cologuard

Yes No Date: _____

Fecal Occult Blood Test

Yes No Date: _____

FEMALE

Genitourinary - FEMALE

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Dysuria (Painful urination)
<input type="checkbox"/>	<input type="checkbox"/>	Hematuria (Blood in urine)
<input type="checkbox"/>	<input type="checkbox"/>	Polyuria (Genitourinary)*
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Frequency**
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence***
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention****

Other: _____

Reproductive - FEMALE

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap
<input type="checkbox"/>	<input type="checkbox"/>	Dysmenorrhea (Painful Menstruation)
<input type="checkbox"/>	<input type="checkbox"/>	Dyspareunia (Pain with sex)
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menses
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge

Other: _____

Mammogram

Yes No Date: _____

MALE

Genitourinary - MALE

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Dribbling
<input type="checkbox"/>	<input type="checkbox"/>	Dysuria (Painful urination)
<input type="checkbox"/>	<input type="checkbox"/>	Hematuria (Blood in urine)
<input type="checkbox"/>	<input type="checkbox"/>	Polyuria (Genitourinary)*
<input type="checkbox"/>	<input type="checkbox"/>	Slow Stream
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Frequency**
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence***
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention****

Other: _____

Reproductive - MALE

No Yes

<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction
<input type="checkbox"/>	<input type="checkbox"/>	Penile Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction

Other: _____

Genitourinary - Definitions

***Polyuria (Genitourinary)**

Excessive urination of more than 3 liters per day

****Urinary Frequency**

The need to urinate many times during the day, at night (nocturia), or both but in normal or less-than-normal volumes.

*****Urinary Incontinence**

Involuntary leakage of urine.

******Urinary Retention**

The inability to completely or partially empty the bladder.

NEW PATIENT INTAKE FORM

We may be prescribing medications electronically and need your permission to access your prescribed medications to avoid drug interactions and duplication. Your signature below will act as permission.

Completing this documentation prior to your appointment does not establish a Patient-Physician Relationship. Information will be reviewed by your provider when you are seen.

I attest the information provided above is true and accurate. I acknowledge I have read, signed and will abide by the Arizona Community Surgeons, PC Patient Payment and Financial Policies.

I ACKNOWLEDGE TYPING MY NAME BELOW CONSTITUTES AN ELECTRONIC SIGNATURE.

Patient's Signature: _____
(or Parent/Guardian if patient is a minor)

Date: _____

Guarantor/Persons liable for bill, if other than the patient: _____

Phone: _____



PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Omnibus Rules of 2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Arizona Community Surgeons, PC (“ACS”), which contains a more complete description of the uses and disclosures of my health information. I understand that ACS has the right to change its Notice of Privacy Practices from time to time and that I may contact ACS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ACS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand ACS is not required to agree to my requested restrictions, but if ACS does agree then ACS is bound to abide by such restrictions.

ACS does not discriminate based on race, age, sex, sexual orientation or ethnicity.

Patient Name: _____ **Patient Date of Birth:** _____
Signature: _____ **Date Signed:** _____

REQUEST FOR CONFIDENTIAL COMMUNICATION

HIPAA privacy rules give certain individuals the right to request confidential medical information. In that regard, you may select the method in which this confidential medical information is communicated. Also, ACS may need to communicate with you regarding your confidential medical information. Please select your preferred method of contact. If you would like to change your contact information in the future, please provide your request in writing to the address contained within the Privacy Practice Notice.

I give permission to disclose my confidential medical information to the following individuals:

Printed Name: _____ Relationship: _____
Printed Name: _____ Relationship: _____
Printed Name: _____ Relationship: _____

My EMERGENCY contact is: _____ **Phone** _____

I prefer to be contacted in the following manner (X all that apply):

____ Home Phone: _____ Detailed Message OR ____ Callback Number Only
____ Work Phone: _____ Detailed Message OR ____ Callback Number Only
____ Cell Phone: _____ Detailed Message OR ____ Callback Number Only

Written Communication: I give my consent to be contacted in the following ways:

Mail to Home Email to: _____ Fax to: _____

I ACKNOWLEDGE TYPING MY NAME BELOW CONSTITUTES AN ELECTRONIC SIGNATURE:

Signature: _____ **Date Signed:** _____

ACS OFFICE USE ONLY:

I attempted to obtain the patient’s signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Employee Name: _____

Reason: _____



ARIZONA
COMMUNITY
SURGEONS, PC

Patient Name: _____

Date of Birth: _____

Address: _____

Arizona Community Surgeon (ACS) Attestation

I acknowledge I have received the documents from Arizona Community Surgeons and consent to the following: (initials and signatures required):

_____ Notice of Privacy and HIPAA

_____ ACS Finance Policy I have read and agree to this Payment Policy, Assignment and Release of Information stated in the policy. I acknowledge my financial responsibility related to the services provided by Arizona Community Surgeons, PC.

_____ Prescriptions and Narcotics Agreement

_____ I give ACS permission to obtain my medication history

_____ I hereby consent to the clinical exam and treatment to be provided.

_____ I give ACS permission to bill my insurance company for services and/or product(s) received on my behalf. (if applicable).

My signature is acknowledgement of receipt of these documents. I understand I am responsible for reviewing and understanding the information provided by ACS and agree to comply. My signature confirms the information provided to ACS is true and accurate. I give ACS permission to bill my insurance company for services and/or product(s) received on my behalf. (if applicable). I acknowledge typing my name below constitutes an electronic signature.

Patient Signature

Date