New Patient Intake

Name

First Name | Middle Initial | Last Name

Date of Birth:

Gender:

Relationship Status:

Street Address: **Apt./Unit #:**

City: **State:** **Zip Code:**

Preferred Phone: **Ok to text? *** **Ok to leave voicemail? ***

Email address: **Ok to receive emails? ***

Preferred contact method:

Type of parking available

Pets at home? **If yes, type of pet?**

Emergency Contact Name

Phone Number

Relationship

OK to share your personal health information with this person? *

SURGEON/PHARMACY

Name of surgeon *

Surgeon phone number

Ok to speak w/ your surgeon regarding your care? *

Preferred Pharmacy

OK to speak w/ pharmacy regarding your care? *

Pharmacy address and phone number

Check if you have or have had any of the following:

	Asthma/breathing problems		High blood pressure
	Arthritis, rheumatism		HIV AIDS
	Artificial joints, pins, etc.		Kidney disease
	Bleeding abnormally		Liver disease
	Blood disease		Neurological disease
	Bowel/stomach problems		Psychiatric disorders
	Cancer		Pulmonary embolism/DVT
	Chemical dependency		Radiation treatment
	Circulatory problems		Respiratory disease
	Diabetes		Rheumatic fever
	Epilepsy Fainting		Seizure/epilepsy
	Headaches		Stroke
	Heart murmur		Swelling of feet or ankles
	Heart problems		Thyroid problems
	Hemophilia		Ulcer
	Hepatitis		Other pertinent

Have you had any serious illnesses or operations? If yes, please describe

List medications you are currently taking and the correlating diagnosis:

	Medication	Purpose
1.		
2.		
3.		
4.		
5.		
6.		

Please list any allergies you may have:

	Allergy	Reaction
1.		
2.		
3.		
4.		
5.		
6.		

CURRENT HISTORY

Are you currently under medical care?

If yes, please explain

Primary Care Physician name and phone number

Reason for today's visit (your primary concern):

How did you hear about our office?

Client Signature *