New Patient Intake Form

A copy of your insurance card(s) and photo ID is required.

Patient Information:

____
(Legal Name: Last / First / Middle)

Preferred Name (*if different*): ______________________________ DOB: _____ / _____ / _______

Sex: ☐ Female ☐ Male ☐ Other: ______________ ☐ Prefer not to say

Cell Phone (primary): _____________________________________ ☐ OK to leave detailed message

Email Address:____

Social Security Number (if provided): ___________________________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Insurance Name & ID #: ____
☐ N/A due to Self Pay

ADDRESS & CONTACT INFORMATION

Street Address: ____

City: ______________________ State: ________ Zip: __________ County: ___________

PHARMACY INFORMATION:

Primary Pharmacy Name & Address:

____

Mail-Order / Secondary Pharmacy Name & Address:

____

EMERGENCY CONTACT:

____
Name ***Relation*** ***Phone No.***

____
Name ***Relation*** ***Phone No.***

____
Name ***Relation*** ***Phone No.***

Health Overview

REASON FOR TODAY'S VISIT:

____

CURRENT HEALTH CONCERNS:

____

____

CURRENT MEDICATIONS:

☐ None

☐ Attached Separately -or- listed below (med name & dosage/direction):

____ ____

____ ____

ALLERGIES/REACTIONS:

☐ No Known Drug Allergies

OR listed below (allergy/reaction:

____

SURGICAL HISTORY ***(please list prior surgeries and approximate dates performed)*****:**

____

MEDICAL CONDITIONS (check if applicable):

☐Allergies/Hay Fever	☐ Anemia	☐ Anxiety	☐ Asthma
☐ Dementia/Alzheimers	☐ Depression	☐ADD/ADHD	☐ COPD
☐ High Blood Pressure	☐ Obesity	☐ High Cholesterol	☐ Migraines
☐ Diabetes (Type:______)	☐ Thyroid Disease	☐Heart Disease: ______________________	
☐ Cancer: ______________________________		☐ Other: ______________________________	

HEALTH SCREENING HISTORY (please list all health screenings as applicable):

Last Menstrual Period: ______________________________ ☐ Normal ☐ Abnormal

(Date)

Colonoscopy: ☐ Normal ☐ Abnormal

____

(Colonoscopy Date & Location Completed)

Mammogram: ☐ Normal ☐ Abnormal

____

(Mammogram Date & Location Completed)

DEXA (Bone Density Scan): ☐ Normal ☐ Abnormal

____

(Bone Density Scan Date & Location Completed)

PAP Smear: ☐ Normal ☐ Abnormal

____

(PAP Smear Date & Location Completed)

LIFESTYLE:

Smoking/Vaping: ☐ Never ☐ Former ☐ Current

If former, quit: __________ If current: ☐ Daily ☐ Weekly

Alcohol Use: ☐ None ☐ ~4 drinks/month ☐1-4 drinks/week ☐1-2 drinks/day ☐3+

Marijuana:☐ Never ☐ ~4 times/month ☐ 1-4 times/week ☐ Daily Other drugs: _______________

Additional Information *(optional)*

Preferred Pronouns: ________________________ Gender Identity: __________________________

Living Situation: ☐ Single ☐ Married ☐ Partnered ☐ Other: _____________________

Children: # of Children: ___________ # living with you: ___________

Employment Status:

☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Student ☐ Unemployed/Retired

Occupation & Employer (if applicable): ____

Do you have any other concerns you would like your provider to be aware of?

____

Authorization to Verbally Disclose Protected Health Information (PHI)

(This authorization may be revoked at any time in writing)

Permission to verbally discuss protected health information with Family Members/Caregivers

I give permission for Elite Primary Care to discuss my health information with:

____

Name ***Relation*** ***Phone No.***

____

Name ***Relation*** ***Phone No.***

____

Name ***Relation*** ***Phone No.***

-or-

☐ I DECLINE. Please do not discuss my care with anyone other than allowed by HIPAA regulations

Permission to leave detailed message

I give permission for Elite Primary Care to leave a detailed message by the following methods:

☐ Cell Phone (call) ☐ Email ☐ Patient Portal

-or-

☐ I DECLINE. Please do not leave me detailed messages.

FINANCIAL RESPONSIBILITY INFORMATION

☐ **Self**

☐ Someone else (COMPLETE section below)

Subscriber Name: ____ DOB: ___ / ___ / _____

Relationship to Patient: ___________________________

Address: ____

City: _____________________ State: ______ Zip: ___________

Cell Phone: ________________ Email: ____

Patient Acknowledgement & Consent

Please carefully read, review and initial each item below:

_______ ***I acknowledge that I have received, reviewed, or been given the opportunity to review Elite Primary Care's Notice of Privacy Practices (HIPAA), Financial Policy, and No Show/Late Cancellation Policy, whether provided electronically or in-office.***

_______ ***I understand and agree to the Financial Policy, including responsibility for all charges not covered by insurance.***

_______ ***I understand and agree to the No Show / Late Cancellation Policy, including a $50 fee for missed or late appointments or cancellations with less than 24 business hours' notice.***

_______ ***I understand that a card on file is required and authorize its use for applicable balances, including copays, deductibles, coinsurance, and outstanding charges in accordance with clinic policy.***

Card on File:

Last 4 digits of card: ___ ___ ___ ___ Exp. Date: _____ / _____ Billing Zip Code: ____________

Card Type *(HSA and AmEx preferred)*: ☐HSA ☐AmEx ☐Visa ☐MC ☐Discover ☐Other:__________

____

Cardholder Name & Signature *Date*

**Card information is securely stored in compliance with applicable payment security standards. Only the last 4 digits are recorded on this form for verification.*

_______ ***I understand that failure to provide required information may delay my appointment or care, and that full copies of all policies are available upon request or online.***

By signing below, I acknowledge and agree to the above statements.

____

Printed Name & Signature of Patient or Legal Representative (w/ Relationship) ***Date***