SELECT PRIMARY CARE

Adult New Patient Intake and Consent Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Address: _____

City:_____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Sex: _____ Place of birth: _____ SS#:_____

Marital Status: _____ Spouse Name: _____

Emergency Contact: _____Relationship: _____

Emergency Contact Phone: _____

Patient Occupation: _____ Employer: _____

Employer's Address: _____

Preferred Pharmacy Name:_____

Pharmacy Address: _____

Pharmacy Telephone Number: _____

Please list ALL active treating doctors (i.e. gynecologist, pulmonologist, oncologist, cardiologist, surgeon, etc.)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Laboratory Information

Please indicate preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories. Failure to follow their guidelines can lead to bills that become patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier.

[ ] Quest [ ] Labcorp [ ] Other_____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients

Race:

[ ] American-Indian or Alaska Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian
[ ] White
[ ] Other

Ethnicity:

[ ] Hispanic or Latino
[ ] Specify: _____

Preferred Language: _____

Insurance Information

Primary Insurance Company: _____ID/Group Number:_____

Secondary Insurance (if applicable): _____

Primary Subscriber's Name (if other than patient)_____

It is your responsibility to keep our office updated your correct insurance information.

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Select Primary care for services rendered. I authorize representatives of Select Primary Care to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Any services filed with your insurance that not responded after 90 days from date of service may be transferred to patient balance. A monthly statement will be sent to you detailing unpaid charges. If you have questions regarding items which have not been paid by your insurance, we ask that you contact your insurance company.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the Select Primary Care Notice of Privacy Practices.

SELECT PRIMARY CARE

Cancellation – Rescheduling Policy

No show, cancellations or rescheduling within 24 hours of appointment is subject to $100 charge.

HIPAA Policy

We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

Your provider and office staff members may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you.

You may restrict the individuals to which your health care information is released. Please complete the below chart as to whom you authorize to receive your health information:

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

The following information may be disclosed to the above mentioned name(s). Please check all that apply: [ ] All information [ ] Results only [ ] Appointment status

Protected health information may be disclosed via (please check all that apply):

[ ] Home voicemail [ ] Mobile voicemail [ ] Email

By signing I understand and agree to the conditions outlined in this consent form.

_____ _____

PRINT NAME **SIGNATURE**

_____

DATE

SELECT PRIMARY CARE

General Medical Questionnaire

Reason for your visit today?_____

Have you EVER had any of the following?

Asthma/COPD/Breathing problems…….[ ] Y [ ] N

Arthritis…….[ ] Y [ ] N

Bleeding/Clotting Disorder…….[ ] Y [ ] N

Blood pressure disorder……....[ ] Y [ ] N

Blood transfusion……[ ] Y [ ] N

Bowel/Stomach Problems……[ ] Y [ ] N

Cancer……..[ ] Y [ ] N

Cholesterol Disorder……...[ ] Y [ ] N

Diabetes……[ ] Y [ ] N

Eye Disorder (Glaucoma, Cataract)……. [ ] Y [ ] N

Heart Disease……[ ] Y [ ] N

Lung Disorder……[ ] Y [ ] N

Liver Disease……..[ ] Y [ ] N

Neurological Disorder/headaches...[ ] Y [ ] N

Psychiatric Disorder/Illness……..[ ] Y [ ] N

Pulmonary embolism/DVT……[ ] Y [ ] N

Stroke…….. [ ] Y [ ] N

Seizure/Epilepsy……[ ] Y [ ] N

Thyroid Disorder……[ ] Y [ ] N

Urinary/Kidney Disorder……[ ] Y [ ] N

If relevant: Gynecological Issues…….[ ] Y [ ] N

Please list any other medical issues or problems and provide details for any of the above conditions:

_____

_____

_____

_____

Please list all past surgeries and hospitalizations and the approximate date:

Surgeries/Hospitalization(s)	Date

Do you currently smoke? [ ] Y [ ] N How much do you smoke? _____

Former Smoker [ ] Y [ ] N When did you quit?_____

Consume alcohol? [ ] Y [ ] N If yes, drinks/week: _____

If relevant: Any past pregnancies? [ ] Y [ ] N How many? _____ How many deliveries? _____

Last menstrual cycle: _____ Last PAP smear: _____ Mammogram:_____

Flu Vaccine:_____ Pneumococcal Vaccine: _____

Please indicate any major conditions/illnesses that your immediate family members have had:

Father:_____ Living? [ ] Y [ ] N

Mother:_____ Living? [ ] Y [ ] N

Siblings: _____

Other: _____

Family history of cancer? _____

Do you have any allergies? [ ] Y [ ] N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

_____

_____

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication	Dose and Frequency