ASEPTIC PRIMARY & FAMILY PRACTICE CLINIC LLC

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NEW PATIENT INTAKE FORM

I. Patient Information

Patient Name _____
DOB _____**Age** _____ **Sex M or F**
Address _____
City _____**State** _____**Zip** _____
Social Security # _____
Home Phone _____**Mobile** _____**Work Phone** _____
Email Address _____
Whom may we thank for referring you?_____

II. Emergency Contact

Name _____**Relationship** _____
Contact Number/s _____

III. Insurance

Who is responsible for this account _____**Relationship** _____
Primary Insurance _____
ID # _____**Group #** _____
Subscriber Name _____
Birth Date _____**SS#** _____

IV. Basic Health Information

Primary Care Provider _____**Date Last Seen** _____
Recent Hospitalization _____
Preferred Pharmacy Name and Location _____

V. Medical History

Surgeries

Type of Surgeries	Date (Approximate)	Hospital

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Family History

	Yes	No	Family members
Cancer (Type)			
Diabetes			
Heart Attack/Stroke			
Alzheimer's / Dementia			
Psychiatric – Bipolar, Schizo			
Other			

Social History

	Current	Former	Plans of quitting
Cigarettes			
Alcohol Use			
Street drugs			
Other			

Allergies

Name of Allergen	Reaction	Onset date

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VI: Reason for Visit

Chief Complaint today: _

Check all that apply:

Anxiety	Stroke	Osteoarthritis	Asthma
Depression	A-fib	Back Pain	COPD
Bipolar	Blood Clot	Chronic pain synd.	Chronic Sinusitis
Schizophrenia	Diabetes	Constipation	Allergies
Insomnia	Hypertension	Hypothyroidism	Sleep Apnea
Migraine	CHF	Seizures	Cancer
Alzh/ Dementia	Edema	Parkinson's	Stomach ulcer
Gait abnormality	High cholesterol	Anemia	Pneumonia
Other:	Other:	Other:	Other:

File Upload (health record, labs, or relevant documents):

Current Medications and dosages: