Practice: **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Race: _____ ☐I prefer not to answer ☐I do not know

(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ ☐I prefer not to answer ☐I do not know

Preferred Language: _____ ☐I prefer not to answer

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone**:** _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s):_____

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker

☐ Current Some Day Smoker ☐ I decline to answer

☐ Former Smoker

Vital Signs

Blood Pressure: _____ / _____

Height: _____Weight: _____

Current Medications

☐ No Known Medications

☐ I take the following prescriptions/over the counter medications:

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies

☐ No Known Drug Allergies **Reaction**

☐ Penicillin _____

☐ Shellfish _____

☐ Sulfa _____

☐ Tape _____

☐ Latex _____

☐ Betadine *(iodine)* _____

☐ Aspirin _____

☐ Tylenol™ _____

☐ Ibuprofen _____

☐ Codeine _____

☐ Other *(specify)*_____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____