

INTAKE FORM

Welcome To Our Office

Date: _____

PATIENTS NAME (PLEASE PRINT)	S.S.#:	MARITAL STATUS S M W D	BIRTH DATE	AGE	RELIGION (OPTIONAL)
STREET ADDRESS		CITY, STATE		ZIP CODE	HOME PHONE #
PATIENT'S OR PARENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)		EMPLOYED	BUS. PHONE# EXT. #
EMPLOYER'S STREET ADDRESS			CITY, STATE		ZIP CODE
DRUG ALLERGIES, IF ANY					
INSURANCE SUSCRIBER'S NAME/IF DIFFERENT FROM ABOVE			S.S.#:		BIRTH DATE
SUSCRIBER'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)		EMPLOYED	BUS. PHONE # EXT.#
EMPLOYER'S STREET ADDRESS		CITY, STATE		ZIP CODE	
PLEASE LIST ANY CHANGES TO THE ABOVE INFORMATION BELOW					

E-Mail: _____

Cell: _____

Pharmacy Name: _____

City, State, and Zip: _____

Primary Care Doctor: _____

Tel #: _____

Insurance: _____

ID: _____

Subscriber Name: _____

Subscriber DOB: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

My Insurance participating physician, other health care professional has also informed me that they (the physician or other health care professional) may or may not have financial interest in the referred-to health care facility or other entity. And, receive compensation from the referred-to physician, other health care professional or facility. I acknowledge that by signing this Consent Form that I have been informed by my physician and have of a participating physician, other health care professional or facility within the network chosen to receive services by their covering physicians.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. If this account is assigned to an attorney for collection and/ or suit, the undersigned agrees to pay 33 1/3% of the claim and payment for attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled to: _____ M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I will be responsible for fees incurred during preliminary work-up or pre-admission testing. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

Acknowledgment of Receipt of Privacy Notice – I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the consents of the notice, and subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice: _____

Signature of Patient (Legal Guardia, Healthcare Representative or Next of Kin)

Date

Print Name and Relationship, if other than Patient

Name _____ Age _____ Today's Date _____

Date of last Pap Smear: _____ Was it normal? _____ Please explain: _____

Date of last mammography: _____ Was it normal? _____ Please explain: _____

First day of last menstrual period: _____ Was it normal? _____ Please explain: _____

Age at time of first period: _____ Length of menstrual cycle: _____ Bleeding for how many days? _____

Any problems or pain with period? _____ If so, explain: _____

Current method of birth control: _____

Any history of sexually transmitted diseases? _____

Pregnancy History: Total pregnancies _____ Total births _____ Induced abortions _____ Miscarriages _____

Month/Year	Length of Pregnancy	Labor Duration	Vaginal or C-Section	Sex of Baby	Birth Weight

Complications of birth for you or your baby? _____

Please list surgeries and/or hospitalizations you have had: _____

Please list all medications and vitamins you are now taking: _____

Please list any drug allergies and the type of reaction you have: _____

Do you or anyone in your family have any significant medical history, i.e. high blood pressure, heart disease, cancer, migraines...?

Please explain _____

Immunizations: Flu NO YES _____ Date _____ Hepatitis B NO YES _____ Date _____ OTHER: _____
MMR NO YES _____ Date _____ Pneumovax NO YES _____ Date _____ OTHER: _____
Tetanus NO YES _____ Date _____ Varicella NO YES _____ Date _____ OTHER: _____

Habits: Do you smoke cigarettes? YES NO _____ packs per day
Do you drink alcohol? YES NO _____ ounces per week
Do you use drugs? YES NO _____
Do you drink coffee or tea? YES NO _____ cups per day
Do you exercise regularly? YES NO _____
Do you wear seat belts? YES NO _____
Do you do monthly self breast examinations? YES NO _____
Have you put yourself at risk of getting AIDS? YES NO Do you wish to be tested for AIDS? YES NO

Nombre _____ Edad _____ Fecha de hoy _____

Fecha de su última prueba de Papanicolau _____ ¿Fue normal? _____ Por favor explique _____

Fecha de su última mamografía _____ ¿Fue normal? _____ Por favor explique _____

Primer día de su último periodo mensual _____ ¿Fue normal? _____ Por favor explique _____

Edad que Ud. tenía cuando comenzó a menstruar _____ ¿Por cuantos días está sangrando? _____

¿Algún problema o dolor durante su menstruación? _____ Por favor explique _____

¿Que método usa para el control natal? _____

¿Ha pedecido de alguna enfermedad trasmitida sexualmente? _____

Número de embarazos _____ Total de alumbramientos _____ Abortos _____ Abortos involuntarios _____

Mes/Año	Duración del embarazo	Duración del parto	Vaginal o Cesarea	Sexo del bebé	Peso al nacer

¿Tuvo Ud. o el bebé algunas complicaciones a la hora del alumbramiento? _____

Por favor enumere las cirugias y/o hospitalizaciones que Ud. ha tenido: _____

Por favor enumere los medicamentos y las vitaminas que esta tomando en el presente: _____

Por favor enumere algunas alergías a medicamentos que Ud. tiene: _____

Por favor explique si Ud. o algún miembro de su familia padece de alguna enfermedad significativa, como presión alta, enfermedades del corazón, cancer, migrana etc, etc _____

VACUNAS:	Influenza	NO	SÍ _____ Fecha	Hepatitis B	NO	SÍ _____ Fecha	OTRAS: _____
	MMR	NO	SÍ _____ Fecha	Neumonía	NO	SÍ _____ Fecha	OTRAS: _____
	Tétano	NO	SÍ _____ Fecha	Varicela	NO	SÍ _____ Fecha	OTRAS: _____

- ¿Fuma Ud. cigarillos? SÍ NO _____ paquetes al día
- ¿Toma Ud. bebidas alcohólicas? SÍ NO _____ onzas a la semana
- ¿Toma Ud. drogas? SÍ NO _____
- ¿Toma Ud. café o te? SÍ NO _____ tazas por día
- ¿Hace Ud. ejercicio regularmente? SÍ NO _____
- ¿Usa Ud. el cinturón de seguridad cuando viaja? SÍ NO _____
- ¿Se examina Ud. misma los senos mensualmente? SÍ NO _____
- ¿Se ha puesto Ud. en el riesgo de contaminarse de SIDA? SÍ NO ¿Quisiera Ud. hacerse la prueba de SIDA? SÍ NO