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**Patient Intake Form**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Name: First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female \_\_\_\_\_ Male\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information:**

Mobile Phone # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone# (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred contact # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive notifications via email: Yes \_\_\_\_\_\_ No\_\_\_\_\_\_

What is your preferred method of communication?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PO Box \_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Information:**

Payment Preference\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID/Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guarantor:**

Guarantor/Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Female/Male SSN \_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Demographics:**

Preferred Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: White \_\_\_\_\_\_\_\_ American Indian or Alaska Native \_\_\_\_\_\_\_\_\_\_

Asian \_\_\_\_\_\_\_\_ Black or African American \_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_

**Next of Kin:**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # (\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

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**Patient History Form**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Name: First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (Prescription & Over the Counter/Vitamins) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History** (*Please circle or list)***:**

Diabetes Hypertension High cholesterol Thyroid disease Osteoporosis

Arthritis Lung Disease Heart Disease Heart Attack Stroke

Depression Anxiety Bowel Disease Heartburn/Reflux Migraines

Obstructive Sleep Apnea

# Pregnancies \_\_\_\_\_ # Live births \_\_\_\_\_\_\_ # Miscarriages \_\_\_\_\_\_\_\_

Other, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History/Hospitalizations** (Please list and include date)**:**

Please list any past surgeries and/or hospitalizations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Father: Living / Deceased Age of death\_\_\_\_\_ Health History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Living / Deceased Age of death \_\_\_\_\_ Health History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: # of brothers \_\_\_\_ Health history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of sisters \_\_\_\_\_ Health history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of children \_\_\_\_\_\_\_\_\_\_\_ Health history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Married/Single/Divorced/Widowed Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use: Yes / No If yes, Type \_\_\_\_\_\_\_\_\_\_\_\_\_ Number of years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use: Yes / No Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # per day \_\_\_\_\_\_\_\_\_ # per week \_\_\_\_\_\_\_\_

Caffeine Use: Yes / No If Yes, Type\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you used illicit drugs? Yes / No Type\_\_\_\_\_\_\_ Do you wear your seatbelt? Yes / No

Do you exercise regularly? Yes / No Type of exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often \_\_\_\_\_\_\_

**Health Maintenance:**

Last Pap screening \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last DEXA Scan/Bone Density \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last PSA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Lipid Panel test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last stool test for blood\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Tetanus/Tdap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_

Have you ever received a shingles vaccination? Yes / No If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received a pneumonia vaccination? Yes / No If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you were born between 1945 - 1965, have you ever been screened for Hepatitis C ? Yes / No

**HIPAA Privacy Act Patient Consent Form**

The Health Insurance Portability and Accountability Act (HIPAA), requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is protected and safe. As our patient, we want you to know that we respect the privacy of your personal medical care and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect that privacy.

When appropriate and necessary, we provide the minimum information about treatment, payment or health care operations in order to provide health care that is in your best interest. Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to release any medical information and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you.

Four Seasons Wellness, PLLC notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

**Name of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message on your answering machine or with a family regarding appointment and reminders, insurance issues, and/or request for you to call the office? **YES** \_\_\_\_\_\_ **NO** \_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release Information**

Patients may allow family members such as their spouse, children, parents or others such as friends, to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits and/or request results of tests and procedures. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends, you must sign the consent below. This consent form will not allow our office to release any other information about you other that what is listed above. The HIPAA consent is **valid up to one year**. However, you have the right to revoke this consent, in writing, prior to expiration of that one year.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling appointments, to go over insurance benefits, and/or the results of tests and/or procedures.

1. **Individual Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. **Individual Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. **Individual Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Guardian**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_