FAMILY MEDICINE SPECIALISTS NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

FIRST NAME: _____ LAST NAME: _____

MALE: _____ FEMALE: _____ DATE OF BIRTH: _____SS#_____

STREET ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: _____CELL: _____

WORK PHONE: _____ EMAIL: _____

MARITAL STATUS: _____

IF MARRIED SPOUSE'S NAME: _____

DO YOU HAVE ANY CHILDREN? _____IF YES HOW MANY? _____

IF PATIENT IS A MINOR,
PARENT/GUARDIAN NAME: _____

Race: American Indian or Alaska Native _____ Asian_____ Black or African American_____ White_____
Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____
Refused to Answer_____
Preferred Language: English_____ Spanish_____ Other_____ What_____

EMPLOYER NAME: _____

FULL ADDRESS: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE NUMBER: _____

EMERGENCY CONTACT ADDRESS: _____

CONSENT FOR TREATMENT:

THE UNDERSIGNED ACKNOWLEDGES THAT HE/SHE HAS VOLUNTARILY REQUESTED THE MEDICAL HEALTHCARE SERVICES OF THE ABOVE CLINIC AND FURTHER CONSENTS TO ANY AND ALL MEDICAL PROCEDURES AND/OR TREATMENTS WHICH ARE DEEMED MEDICALLY NECESSARY BY THE ATTENDING PHYSICIAN AND/OR HEALTH CARE PROFESSIONALS.

SIGNATURE: _____ DATE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:
PHONE NUMBER:	PHONE NUMBER:
MEMBER ID#:	MEMBER ID#
GROUP#:	GROUP#:
GUARANTOR NAME:	GUARANTOR NAME:
GUARANTOR ADDRESS:	GUARANTOR ADDRESS:
GUARANTOR PHONE#:	GUARANTOR PHONE#:
GUARANTOR DATE OF BIRTH:	GUARANTOR DATE OF BIRTH:
GUARANTOR SS#:	GUARANTOR SS#:
GUARANTOR EMPLOYER:	GUARANTOR EMPLOYER:
RELATION TO PATIENT:	RELATION TO PATIENT:

MEDICAID/HEALTH CONNECT/KID CARE? YES_____ NO_____

CASE ID# _____RECIPIENT#_____

ASSIGNMENT OF BENEFITS/MEDICAL INFORMATION RELEASE

I request that payment of authorized Medicare/ Insurance benefits be made on my behalf to the above named doctor/group for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.
I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. I hereby assign benefits to the doctor or group indicated on this claim. Having insurance is not substitute for payment. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature: _____Date: _____

PRIMARY CARE PHYSICIAN: _____

FULL ADDRESS: _____

PHONE NUMBER: _____

I authorize Family Medicine Specialists to release my entire medical record to the above listed physician with no limitations unless noted below. I understand that I may revoke this consent at any time with a written request except to the extent that action has been in reliance thereon.

Signature: _____ Date: _____

LIFESTYLE INFORMATION

DO YOU USE TOBACCO? YES____ NO ____ IF YES, WHAT KIND? _____

IF STOPPED, HOW LONG AGO? _____

HOW MUCH TOBACCO DO/DID YOU USE EACH DAY? _____

DO YOU DRINK ALCOHOL? YES ____ NO ____ IF YES, WHAT KIND? _____

HOW MUCH ALCOHOL DO YOU CONSUME WEEKLY? _____

IF YOU HAVE STOPPED, WHEN DID YOU STOP? _____

DO YOU DRINK CAFFEINATED COFFEE, SODA, OR TEA? YES____ NO ____

HOW MUCH COFFEE, SODA, OR TEA DO YOU DRINK DAILY? _____

IN WHAT PHYSICAL ACTIVITIES DO YOU PARTICIPATE? (CHECK ALL THAT APPLY)

	WALK		YOGA		HOUSE/YARD WORK
	RUN		TAI CHI/QI GONG		HIKING
	WEIGHTS		DANCING		FLEXIBILITY EXERCISE
	BICYCLING		SWIMMING		WEIGHT TRAINING
	PILATES		GO TO GYM		RESISTANCE TRAINING

FAMILY HISTORY (CHECK ALL THAT APPLY)

	CHILDREN	MOTHER	FATHER	SIBLINGS	MATERNAL GRANDPARENTS	PATERNAL GRANDPARENTS
THYROID PROBLEMS						
DIABETES						
HEART DISEASE						
MENTAL DISEASE						
STROKE						
HEART ATTACK						
EPILEPSY/SEIZURES						
CANCER						
ASTHMA						
ANEMIA						
DRUG OR ALCOHOL ABUSE						
HIGH BLOOD PRESSURE						
BIRTH DEFECT						
OTHER						

MEDICAL HISTORY

ALLERGIES
PLEASE LIST ANY MEDICATIONS, FOOD, ENVIRONMENT, OR OTHER ALLERGY.

1) _____

2) _____

3) _____

HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESS

DATE CONDITION OR PROCEDURE

1) _____ _____

2) _____ _____

3) _____ _____

MEDICATIONS
PLEASE LIST THE MEDICATION AND DOSAGES THAT YOU ARE CURRENTLY TAKING. PLEASE INCLUDE BOTH PRESCRIPTION AND OVER THE COUNTER.

MEDICATION DOSAGE

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

SUPPLEMENTS
PLEASE LIST ALL OF THE SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING INCLUDING DOSAGES AND BRAND NAMES.

SUPPLEMENT DOSAGE BRAND

1) _____

2) _____

3) _____

4) _____

NOW	PAST	GENERAL SYMPTOMS		NOW	PAST	EYES
		TIRED, WEAK, LACK OF ENERGY				NEARSIGHTEDNESS/FARSIGHTEDNESS
		DEPRESSION AND MOODINESS				BLURRED OR FAILING VISION
		WORRY, ANXIETY, NERVOUSNESS				DRY, BURNING, OR ITCHY EYES
		SLEEPLESSNESS OR TOO MUCH SLEEP				EYES WATER EXCESSIVELY
		FREQUENT COLDS AND OTHER ILLNESSES				NIGHT BLINDNESS
		HEADACHES				BLOOD SHOT, RED, OR PUFFY EYES
		DIZZINESS, FAINTING, OR BLACKING OUT				MUCOUS OR DISCHARGE IN EYES
		DON'T SWEAT ENOUGH/TOO MUCH SWEAT/NIGHT				PAIN IN EYES

		SWEATS				
NOW	**PAST**	**EARS**		**NOW**	**PAST**	**CHEST**
		EARACHES				COUGHS FREQUENTLY
		NOISES OR RINGING IN EARS				SPITTING UP MUCOUS OR BLOOD
		EAR DISCHARGES				DIFFICULTY BREATHING
		LOSS OF HEARING				CHEST PAIN
		EXCESS EAR WAX				WHEEZING
		DIFFICULTY HEARING				PALPITATIONS
NOW	**PAST**	**SKIN AND HAIR**		**NOW**	**PAST**	**NOSE AND THROAT**
		ACNE OR PIMPLES				ALLERGIES, SINUSITIS, RUNNY NOSE
		HIVES				DRY MOUTH OR NOSE
		STRETCH MARKS				NOSE BLEEDS
		SKIN ULCERS OR SORES				CRACKS IN CORNERS OF MOUTH
		DRYNESS, ROUGHNESS, OR SCALING SKIN				DRY OR CHAPPED LIPS
		HAIR LOSS OR THINNING				SORE THROAT OR TONSILLITIS
		DRY OR COURSE HAIR				SORE, RED, OR CRACKED TONGUE
		BRUISE EASILY				COLD SORES OR HERPES
		NAILS WEAK, RIGID, OR SPLIT EASILY				LOSS OF SMELL OR TASTE
		BROWN SPOTS OR BRONZING ON SKIN				BLEEDING GUMS
		WARTS, MOLES, OR SKIN TAGS				HOARSENESS
		SUN BURN EASILY				GRINDING TEETH
		CUTS HEAL SLOWLY OR SCAR BADLY				DENTAL PROBLEMS
		FLUSH EASILY				DIFFICULTY SWALLOWING
		ATHLETE'S FOOT				
NOW	**PAST**	**GASTROINTESTINAL**		**NOW**	**PAST**	**CARDIOVASCULAR**
		LOSS OF APPETITE				HEART BEATS FAST OR IRREGULARLY
		NAUSEA OR VOMITING				TIGHTNESS IN CHEST
		BAD BREATH				DISCOMFORT IN HIGH ALTITUDES
		METALLIC OR BITTER TASTE IN MOUTH				DIZZY OR WEAK UPON STANDING
		HEARTBURN				SWOLLEN FEET, ANKLES, OR LEGS
		INDIGESTION				COLD HANDS OR FEET
		HEAVINESS AFTER EATING				HANDS OR FEET TURN BLUE
		BLOATING OR GAS				LEG PAIN WITH WALKING
		BELCHING				HIGH BLOOD PRESSURE
		CONSTIPATION				LOW BLOOD SUGAR
		DIARRHEA		**NOW**	**PAST**	**URINARY**
		LIGHT COLORED OR GREASY STOOLS				DIFFICULTY URINATING
NOW	**PAST**	**GASTROINTESTINAL CONT.**		**NOW**	**PAST**	**URINARY CONT.**
		UNDIGESTED FOOD IN STOOL				URINATE FREQUENTLY AT NIGHT
		BLOOD IN STOOL OR ON PAPER				BED WETTING
		HEMORRHOIDS				INCOMPLETE URINATION OR DRIBBLING
		FOUL ODOR OF STOOL OR GAS				PAIN WITH URINATION
		RECTAL PAIN/ITCHING				BLADDER KIDNEY INFECTION
						KIDNEY STONES
						URINE LEAKAGE
						BLOOD IN URINE
NOW	**PAST**	**FEMALE**		**NOW**	**PAST**	**MALE**
		IRREGULAR PERIODS				PROSTATE PROBLEMS
		PAIN PRIOR TO OR WITH PERIODS				SEXUAL DIFFICULTY
		DEPRESSED/IRRITABLE AROUND PERIODS				GENITAL DISCHARGE
		PAINFUL/SWOLLEN BREAST				RASHES OR SORES
		LUMPS IN BREAST				PAIN IN GENITALS
		NIPPLE DISCHARGE				PAINFUL TESTICLES
		VAGINAL PAIN OR ITCHING				
		VAGINAL DISCHARGE				
		HOT FLASHES				
		DIMINISHED OR EXCESSIVE SEX DRIVE				
		DIFFICULTY REACHING ORGASM				
		INABILITY TO CONCEIVE				
		MISCARRIAGES OR ABORTIONS				
		PELVIC PAIN				
		PAIN WITH INTERCOURSE				

		HEAVY PERIODS				

CONDITIONS

PLEASE CHECK ANY CONDITIONS YOU HAVE HAD.

	AIDS		CHEMICAL DEPENDENCY		HIGH CHOLESTEROL		PROSTATE PROBLEMS
	ALCOHOLISM		CHICKEN POX		HIV POSITIVE		PSORIASIS/ECZEMA
	ALLERGIES		DIABETES		KIDNEY DISEASE		PSYCHIATRIC CARE
	ANOREXIA		EMPHYSEMA		LEG CRAMPS		RHEUMATIC FEVER
	ANEMIA		EPILEPSY		LIVER DISEASE		SCARLET FEVER
	APPENDICITIS		GALL BLADDER DISEASE		MEASLES		STROKE
	ARTHRITIS		GLAUCOMA		MIGRAINE HEADACHES		SUICIDE ATTEMPTS
	ASTHMA		GOITER		MISCARRIAGE		THYROID
	BLEEDING DISORDER		GONORRHEA		MONONUCLEOSIS		TONSILLITIS
	BREAST LUMP		GOUT		MULTIPLE SCLEROSIS		TUBERCULOSIS
	BRONCHITIS		HEART DISEASE		MUMPS		TYPHOID FEVER
	BULIMIA		HEPATITIS		PACE MAKER		ULCERS
	CANCER		HERNIA		PNEUMONIA		VAGINAL INFECTION
	CATARACTS		HERPES		POLIO		VENEREAL DISEASE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ **DATE:** _____

The Family Medicine Specialists
Summary HIPAA Notice of Privacy Practices

Family Medicine Specialists (FMS) complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). FMS protects confidential health care information, known as "Protected Health Information" (PHI). Below is a summary of your privacy rights under HIPPA. FMS' legal duty and privacy practices regarding your PHI are also included in this Summary Notice.

Summary of Your Privacy Rights

FMS may use and give your health information for:

- Treatment
- Payment
- Operation of health care services
- Law enforcement request
- Judicial and administrative proceedings related to legal actions
- Healthcare fraud and abuse
- Detection and compliance with the law
- Use by another healthcare provider treating you
- Government health oversight activities
- Report required by law related to birth, death, or diseases
- Report required by law related to neglect, abuse, or domestic violence
- Notifying a party about exposure to a possible communicable disease
- Use by another healthcare provider for payment to that provider
- Military, national defense, and security or other government functions
- Workman's compensation purposes and in compliance with related laws
- Averting serious threat to public health and safety

You have the right to:

- Inspect or receive a copy of your medical record
- Change information on your medical record if you think it is incorrect
- Get a list of persons whom FMS shared your PHI
- Ask FMS to limit the information it shares
- Ask for a copy of your privacy notice
- Write a letter of complaint to FMS or the federal government

If you have any questions or if you wish to file a complaint, or exercise any rights listed in this Summary or the complete Notice, please contact one of the FMS privacy officers at the telephone numbers listed below.

Jason Bellucci
Office Manager
(847) 526-2151

As part of our compliance to the recent set of federally mandated law, we are giving our HIPPA guidelines to each patient and requesting each patient read the information thoroughly and sign the notification of receipt. This letter will become part of your medical file.

Patient Signature: _____ Date: _____

If minor:

Parent/Guardian Signature: _____ Date: _____