WILLOW VALLEY
Family Medicine & Obstetrics

NEW PATIENT INTAKE AND HISTORY FORM
(Please print)

Date: _____
Name: _____ **Date of Birth:** _____

Local Pharmacy: _____
(Name/City/Phone #)
Mail Order Pharmacy: _____

REASON FOR COMING TO THE DOCTOR TODAY:
Reason for Today's Visit: _____
Timing/Onset: When did symptoms first occur? _____
Duration: Frequency of symptoms? _____
Characterized as/Severity: Describe the severity of the symptoms/pain. _____
Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _____
_____
Modifying Factors: What makes the condition better and/or worse? _____

PROBLEM LIST/PAST MEDICAL HISTORY:
Have you been diagnosed with any of the following (currently or in the past)?

___ Anemia	___ Congestive Heart Failure	___ Heart Attack	___ Obesity
___ Anxiety	___ COPD	___ Heart Disease	___ Pregnancy
___ Arthritis	___ Coronary Artery Disease	___ High Blood Pressure	___ Rheumatic Fever
___ Asthma	___ Coronary Artery Disease	___ High Cholesterol	___ Seasonal Allergies
___ Bleeding Disorder	___ Crohn's Disease	___ HIV	___ Seizures
___ Cancer: _____	___ Depression	___ Irritable Bowel Syndrome	___ Stroke
___ Cataracts, bilateral	___ Esophageal Reflux	___ Kidney Disease	___ Thyroid Disease
___ Chronic Hepatitis	___ Glaucoma	___ Migraine	___ Type 1 Diabetes
___ Congenital Heart Failure	___ Gout	___ Murmur	___ Type 2 Diabetes

___ Other: _____

ALLERGY HISTORY:
☁ **None** ☁ **NKDA (No Known Drug Allergies)**

___ Acetaminophen	___ Epinephrine	___ Latex	___ Penicillin
___ Aspirin	___ Erythromycin	___ Lidocaine	___ Sulfur

_____
_____
_____

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MEDICATION HISTORY:

☁ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	How Often

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Anxiety Disorder						
Arthritis						
Asthma						
Cancer						
Cataract						
Congestive Heart Failure						
COPD						
Coronary Artery Dis.						
Crohn's Disease						
Depression						
Diabetes Mellitus						
GERD						
GI Problems						
High Blood Pressure						
High Cholesterol						
Hyperthyroidism						
Hypothyroidism						
Kidney Disease						
Obesity						
Osteoporosis						
Parkinson's Disease						
Rheumatic Fever						
Seasonal Allergies						
Seizures						
Thyroid Disease						

Other: _____

PAST SURGICAL HISTORY:

☁**None**

___ Angioplasty (stent)	___ Carotid Endarterectomy	___ Hernia Repair	___ Thyroidectomy
___ Appendectomy	___ Cesarean Delivery	___ Hip Replacement	___ Tonsillectomy
___ Back Surgery	___ Cholecystectomy	___ Hysterectomy	
___ Breast Surgery	___ Ear Tubes	___ Neck Surgery	
___ CABG (heart bypass)	___ Hemorrhoidectomy	___ Sinus Surgery	

_____

_____

_____

SOCIAL HISTORY:

Marital status: ☁Single ☁Married ☁Separated ☁Divorced ☁Widowed ☁Child

Work/Student status: ☁Employed ☁Self-employed ☁Unemployed ☁Retired ☁Disabled ☁Full-time student ☁Part-time student

Have you ever been exposed to hazardous chemicals? ☁Yes ☁No

If yes: When : _____ **What:** _____

Living Situation: ☁Lives alone ☁Lives with significant other ☁Lives in home healthcare environment ☁Lives in assisted living facility

Assistive devices: ☁Oxygen ☁Wheelchair ☁Shower Chair ☁CPAP ☁Wheeled Walker ☁Bedside Commode ☁Nebulizer ☁Cane

Please describe your current tobacco use:

☁Smoker, current status unknown ☁Light tobacco smoker ☁Heavy tobacco smoker ☁Current every day smoker ☁Current some day smoker ☁Former smoker ☁Never smoker ☁Unknown if ever smoked

Do you drink alcoholic beverages? ☁Yes ☁No

If yes, please indicate what type of beverage and how many servings per day: _____

Do you drink caffeinated beverages? ☁Yes ☁No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☁Yes ☁No

If yes, please indicate what type of drug and how often: _____

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REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them **recently** or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: Normal
- ❑ Chills
- ❑ Dietary Changes
- ❑ Fever
- ❑ Night Sweats
- ❑ Weight Change

Skin: Normal
- ❑ Acne
- ❑ Bruising
- ❑ Dryness
- ❑ Excessive Sweating
- ❑ Hair Loss
- ❑ Itching
- ❑ New Lesions
- ❑ Rash
- ❑ Skin Color Changes

HEENT: Normal
- ❑ Blurred Vision
- ❑ Eye Redness
- ❑ Headache
- ❑ Hearing Loss
- ❑ Seasonal Allergies

Neck: Normal
- ❑ Neck Mass
- ❑ Swollen Glands

Respiratory: Normal
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Wheezing

Breast: Normal
- ❑ Breast Mass
- ❑ Breast Pain
- ❑ Breast Swelling
- ❑ Skin Changes

Cardiovascular: Normal
- ❑ Heart Stent
- ❑ High Blood Pressure
- ❑ Leg Pain and/or Swelling

Gastrointestinal: Normal
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

Genitourinary: Normal
- ❑ Blood in Urine
- ❑ Frequency
- ❑ Incontinence
- ❑ Painful Urination

Musculoskeletal: Normal
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Swelling of Extremities

Neurological: Normal
- ❑ Dizziness
- ❑ Fainting
- ❑ Loss of Consciousness
- ❑ Numbness
- ❑ Seizures
- ❑ Tingling

Psychiatric: Normal
- ❑ Anxiety
- ❑ Depression
- ❑ Easily Irritated
- ❑ Memory Loss

Endocrine/Glands: Normal
- ❑ Appetite Changes
- ❑ Thyroid Problems

Hematology: Normal
- ❑ Anemia
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Easy Bleeding
- ❑ Enlarged Lymph Nodes

INSURANCE

If you have insurance, please present your cared to the receptionist. We **CANNOT** bill your insurance without a copy of the front and back of your insurance card.

If you do **NOT** have insurance, please request a "payment agreement form" from the receptionist in order to set-up a payment plan. **Payment is due at the time of service.**

HIPAA

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use of disclosure of my protected health information by Willow Valley Family Medicine for the purpose of diagnosing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations. I understand that diagnosis of treatment of me by Willow Valley Family Medicine may be conditioned upon my consent as evidenced by my signature.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Willow Valley Family Medicine is not required to agree to the restrictions that I may request. However, if Willow Valley Family Medicine agrees to a restriction that I request, the restriction is binding on Willow Valley Family Medicine.

I have the right to revoke this consent, in writing, at any time. Except to the extent Willow Valley Family Medicine has taken action in reliance upon this complaint.

My "protected information" means health information, including demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or healthcare clearing house. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Willow Valley Family Medicine's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices of Willow Valley Family Medicine has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Willow Valley Family Medicine. The Notice of Privacy Practices for Willow Valley Family Medicine is also provided in the office of Health Information. This Notice of Privacy Practices also describes my rights and Willow Valley Family Medicine's duties with respect to my protected health information.

Willow Valley Family Medicine reserves the right to change the privacy practices that are now described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Patient Name (Please Print)

_____
Signature of responsible party

_____
Date

Family members okay to receive Medical Info:

_____
_____
_____
_____
_____
_____

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CONSENT TO TREAT

I consent to and authorize Willow Valley Family Medicine to furnish me, and/or my dependents, with necessary medical care. This medical care may include radiology examination, laboratory testing and other diagnostic procedures as may be required.

RELEASE OF MEDICAL INFORMATION

I consent to and authorize Willow Valley Family Medicine to disclose all or part of my, or my dependents, medical records to my mutually agreed upon referring physicians..

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I consent to and authorize Willow Valley Family Medicine to furnish medical information to any third party who may be responsible for payment of all or part of any charges incurred in this office.

I authorize my insurance company, or any responsible third party, to pay benefits directly to Willow Valley Family Medicine.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the payment of medical charges incurred on my, or my dependents, behalf at the office of Willow Valley Family Medicine regardless of third party coverage. Should the account be referred to an attorney of collections agency for collections the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

MEDICARE/MEDICAID BENEFICIARIES (if applicable)

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Willow Valley Family Medicine. I authorize the holder of my medical information to release to the Health Care Financing Administration and its agents any information required to determine those benefits.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

WILLOW VALLEY
Family Medicine & Obstetrics

ESTABLISHED PATIENT INTAKE AND HISTORY FORM
(Please print)

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Name: _____ **Date of Birth:** _____

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Reason for Today's Visit: _____
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