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

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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 menstración?________ 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:____________________

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

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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 significante, como presión alta,

enfermedades del corazón, cancer, migrana etc, etc ____________________

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VACUNAS:							
	Influenza	NO SÍ ________ Fecha	Hepatitis B	NO SÍ ________ Fecha	OTRAS: ________
	MMR	NO SÍ ________ Fecha	Neumonia	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