Practice: **Today's Date:**

Name: ______ **Chart #:** ______ **Date of birth:** ______
Race: ______ ☐I prefer not to answer ☐I do not know
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)
Ethnicity: ______ ☐I prefer not to answer ☐I do not know
Preferred Language: ______ ☐I prefer not to answer
Pharmacy Name: ______ **Pharmacy Phone:** ______
Pharmacy Address: ______ City, State, Zip: ______
Primary Care Physician: ______ Phone: ______ Date Last Seen: ______
Address: ______
Referring Physician: ______ Phone: ______ Date Last Seen: ______
Address: ______

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No
Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No
Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No
If yes, please provide your e-mail address: ______
Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: ______
Name(s): ______

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker
☐ Current Some Day Smoker ☐ I decline to answer
☐ Former Smoker

Vital Signs

Blood Pressure: ______ / ______
Height: ______ Weight: ______

Current Medications

☐ No Known Medications
☐ I take the following prescriptions/over the counter medications:
Name: ______ Dose ______
Name: ______ Dose ______
Name: ______ Dose ______
Name: ______ Dose ______
Name: ______ Dose ______
Name: ______ Dose ______
Name: ______ Dose ______
Name: ______ Dose ______
Use the back of this form if more room is needed

Allergies

☐ No Known Allergies
☐ No Known Drug Allergies **Reaction**
☐ Penicillin ______
☐ Shellfish ______
☐ Sulfa ______
☐ Tape ______
☐ Latex ______
☐ Betadine *(iodine)* ______
☐ Aspirin ______
☐ Tylenol™ ______
☐ Ibuprofen ______
☐ Codeine ______
☐ Other *(specify)* ______

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: ______ **Date:** ______