

## New Patient Intake Form

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Preferred Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Gender: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact Phone: \_\_\_\_\_ Patient Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Primary Care Provider (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_  
PCP Address: \_\_\_\_\_  
Referring Provider: \_\_\_\_\_ Referring Phone: \_\_\_\_\_  
Referring Address: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Pharm Phone: \_\_\_\_\_  
Preferred Pharmacy Address: \_\_\_\_\_

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_  
 Decline Response       Decline Response       Black or African American  
 Hispanic or Latino       American-Indian or Alaska Native       Native Hawaiian or Pacific Islander  
 Not Hispanic or Latino       Asian       White       Other  
Preferred Language: \_\_\_\_\_  Decline Response  
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): \_\_\_\_\_  
Patient or Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

Patient Name (Print): \_\_\_\_\_  
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If completed by a patient's personal representative, please print and sign below.*

Representative (Print): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

Send me an invitation to join myColumbiaDoctors.

Look for an email invite from [noreply@followmyhealth.org](mailto:noreply@followmyhealth.org) and click the Registration link.

Reason for today's visit: \_\_\_\_\_

**General Medical Questionnaire**

Have you EVER had any of the following?

- |   |   |   |   |
|---|---|---|---|
| Asthma/Breathing Problems.....              | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Disease/Disorder.....               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis.....                              | <input type="checkbox"/> Y <input type="checkbox"/> N | Lung Disorder.....                        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bleeding/Clotting Disorder.....             | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Disease.....                        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Pressure Disorder.....                | <input type="checkbox"/> Y <input type="checkbox"/> N | Neurological Disorder/Chronic Headaches . | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Transfusion.....                      | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Disorder/Illness.....         | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bowel/Stomach Problems.....                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Pulmonary Embolism/DVT.....               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer.....                                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke.....                               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cholesterol Disorder.....                   | <input type="checkbox"/> Y <input type="checkbox"/> N | Seizure or Epilepsy.....                  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes.....                               | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid Disorder.....                     | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Eye Disorder (i.e. Glaucoma, cataract)..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Urinary/Kidney Disorder.....              | <input type="checkbox"/> Y <input type="checkbox"/> N |

Please list any other medical illnesses or problems and provide details for any of the above conditions.

Please list any surgeries you have had and the approximate date.

Procedure	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Conditions and description	Living?	If deceased, at what age?
Mother		<input type="checkbox"/> Y <input type="checkbox"/> N	
Father		<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	

 Do you currently smoke?  Y  N If no, previously?  Y  N Years smoked \_\_\_\_\_ Packs/day \_\_\_\_\_

 Do you use other tobacco products?  Y  N Consume alcohol?  Y  N If yes, drinks/week: \_\_\_\_\_

 Do you have any allergies to medications or other substances?  Y  N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis).

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Review of Systems**

Please indicate ALL that you have experienced within the past 6 – 12 months.

General	<input type="checkbox"/> None <input type="checkbox"/> Feeling Tired	<input type="checkbox"/> Fever <input type="checkbox"/> Weight Gain	<input type="checkbox"/> Chills <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Feeling Poorly
Eyes	<input type="checkbox"/> None <input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye Pain <input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Eyesight Problems
Ear/Nose/Throat	<input type="checkbox"/> None <input type="checkbox"/> Sinus problems	<input type="checkbox"/> Earache <input type="checkbox"/> Sore throat	<input type="checkbox"/> Loss of hearing <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Nose bleeds
Heart	<input type="checkbox"/> None <input type="checkbox"/> Slow heart rate	<input type="checkbox"/> Chest pain <input type="checkbox"/> Leg swelling	<input type="checkbox"/> Palpitations <input type="checkbox"/> Leg pain, discomfort, fatigue during walking	<input type="checkbox"/> Fast heart rate
Lungs/Breathing	<input type="checkbox"/> None <input type="checkbox"/> Trouble breathing with exertion	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing <input type="checkbox"/> Trouble breathing when lying flat	<input type="checkbox"/> Shortness of breath
Gastrointestinal	<input type="checkbox"/> None <input type="checkbox"/> Heartburn	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool
Bladder	<input type="checkbox"/> None <input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Incontinence <input type="checkbox"/> Painful period	<input type="checkbox"/> Discolored urine <input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Painful urination
Skin	<input type="checkbox"/> None <input type="checkbox"/> Skin lesions	<input type="checkbox"/> Acne <input type="checkbox"/> Skin wound	<input type="checkbox"/> Itching <input type="checkbox"/> Breast pain	<input type="checkbox"/> Change in a mole <input type="checkbox"/> Breast lump
Neurological	<input type="checkbox"/> None <input type="checkbox"/> Limb weakness	<input type="checkbox"/> Confused <input type="checkbox"/> Loss of memory	<input type="checkbox"/> Convulsions <input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness <input type="checkbox"/> Difficulty walking
Psychiatric	<input type="checkbox"/> None <input type="checkbox"/> Suicidal	<input type="checkbox"/> Anxiety <input type="checkbox"/> Disturbed sleep	<input type="checkbox"/> Depression <input type="checkbox"/> Emotional problems	<input type="checkbox"/> Change in personality
Endocrine	<input type="checkbox"/> None <input type="checkbox"/> Hair loss	<input type="checkbox"/> Weak muscles <input type="checkbox"/> Hot flashes	<input type="checkbox"/> Feeling weak	<input type="checkbox"/> Deepening of voice
Hem/Lymph	<input type="checkbox"/> None	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Swollen glands