



Patient Information

Name (Last, First, MI) _____ Age: _____ Drivers License _____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone#: _____ Social Security #: _____

Work Phone #: _____ E-Mail Address (portal access): _____

Date of Birth: _____ Male Female Marital Status: _____

Advanced Directive: (check one) Yes No I would like information about advanced directives; Organ Donor: Yes No

Patient's Employer: _____ Occupation: _____

Address: _____ City / State / Zip: _____

Guarantor Information

Responsible Party: _____ Social Security #: _____ Relationship: _____

Address: _____ City / State / Zip: _____

Home Phone#: _____ Cell Phone#: _____ Work Phone #: _____

Guarantor's Employer: _____ City State / Zip: _____

Emergency Contact Information

Nearest Relative: _____ Relationship: _____ Social Security # _____

Address: _____ City / State / Zip: _____

Home Phone #: _____ Employer: _____

Employer's Address: _____ City / State / Zip: _____ Work Phone # _____

Notify in Case of Emergency: _____ Relationship: _____

Address: _____ City / State / Zip: _____ Phone #: _____

Financial / Insurance Information

****MUST PRESENT INSURANCE CARD/FORMS, DRIVERS LICENSE AND SOCIAL SECURITY CARD****

METHOD OF PAYMENT: Cash Work Comp Comm Insurance Medicare Medicaid HSA Plan HSA Credit Card

Primary Insurance Carrier: _____ Type of insurance (circle one) HMO PPO POS Other

Policy Number: _____ Group Number or Name: _____ Effective Date: _____

Policy Holder Name: _____ Date of Birth: _____

Employer: _____ Policy Holder's Social Security Number: _____

Relationship to Patient: Self / Spouse / Parent / Other (please explain) _____

Secondary Insurance Carrier: _____ Type of insurance (circle one) HMO PPO POS Other

Policy Number: _____ Group Number or Name: _____ Effective Date: _____

Policy Holder Name: _____ Date of Birth: _____

Employer: _____ Policy Holder's Social Security Number: _____

Relationship to Patient: Self / Spouse / Parent / Other (please explain) _____

Initial

Patient name _____

DOB _____

PAST MEDICAL HISTORY

- Anemia
- Angina Pectoris
- Arthritis
- Asthma
- Low Back Disease
- Bleeding Disorder
- Blood Clots
- Blood Transfusion, if yes, date:
- Cancer
If yes, type(s):
- Colitis
- Constipation
- Depression
- Decreased Sex Drive
- Digestive Problems
- Emphysema
- Epilepsy/Seizures
- Gallbladder Problems
- Gingivitis
- Gout
- Genital Warts
- Heart Arrhythmia
- Heart Valve Disorder
- Heart Attack (MI)
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- Insomnia
- Kidney Failure
- Kidney Stones
- Liver Problems

- Mental Illness
- Migraine Headaches
- Neurological Disorders
- Nervous Breakdown
- Osteoporosis
- Pacemaker
- Pneumonia
- Rheumatic Fever
- Sinusitis, Frequent
- Stomach Ulcers
- Stroke
- Urinary Infections
- Varicose Veins
- Venereal Disease/STD's

- Type 1 Diabetes
- Type 2 Diabetes
- Grave's Disease
- Hashimoto's Disease
- Hypothyroidism

MEN ONLY

- Date of Last Prostate Screen (PSA):
- Date of Last Digital Rectal Exam:
- Erectile Dysfunction
- Low Testosterone

WOMEN ONLY

- Abnormal Pap Smear
- Menstrual Irregularities
- Fibroid Uterine Tumors
- PMS/Menopausal Symptoms
- Polycystic Ovarian Syndrome
- Birth Control Used: _____
- Date of Last Mammogram:
- Date of Last Pap Smear:

EYES, EARS, NOSE, THROAT

- Allergies
- Blindness
- Blurred Vision
- Cataracts
- Glaucoma
- Hearing Loss
- Hoarseness
- Ringing In Ears
- Sinus Problems

PREGNANCIES

- # Live Births: _____
- # Stillbirths: _____
- # Premature Births: _____
- # C-Sections: _____
- # Miscarriages: _____
- # Abortions: _____

SKIN

- Actinic Keratosis
- Psoriasis
- Eczema

ENDOCRINE

HABITS:

Do you currently use tobacco? No Yes If yes, what type? (circle) cigarettes cigars smokeless
 How many per day? _____ How many years smoking? _____ If quit, when _____

Do you use alcohol? No Yes If yes, how much do you drink? _____ drinks per day / week / month / year (circle)

Do you currently use illicit drugs? No Yes If yes, what drug(s) _____

Have you ever had problems with drug use? No Yes If yes, what drug(s) _____

ALLERGIES:

MEDICATION / FOOD / ENVIRONMENTAL EXPOSURE	Mild / Moderate / Severe	Symptoms

Initial _____

Patient name

DOB

2/4

CURRENT MEDICATIONS (use back of page if needed)

Dose

Taken (1e times per day)

	Dose	Taken (1e times per day)

SUPPLEMENTS / VITAMINS / HERBS

Dose

Taken

	Dose	Taken

SURGERIES

Date

Surgeon

	Date	Surgeon

FAMILY HISTORY

Illness/Condition	"X" In appropriate boxes to identify conditions in your blood relatives				Mother's	Mother's	Father's	Father's	If Deceased, cause of death and age
	Father	Mother	Sister(s)	Brother(s)	Mother	Father	Mother	Father	
Colon or Rectal Cancer									
Breast Cancer									
Prostate Cancer									
Thyroid Cancer									
Other Cancer:									
Heart Disease									
Diabetes									
High Blood Pressure									
Liver Disease									
High Cholesterol									
Alcohol/Drug Abuse									
Depression/Psychiatric Illness									
Genetic (Inherited) Disorder									
Other:									

Initial



Ashlee Waugh, M.D.

Wendy Parks, ARNP-CNP

Scott Waugh, M.D.

Cassie Davis, ARNP-CNP

HIPAA Release

- I **RECEIVED** a copy of the Notice of Privacy Practices (HIPPA) for Integrative Medical Solutions
- I **DECLINED** a copy of the Notice of Privacy Practices (HIPPA) for Integrative Medical Solutions

Initial

Cancellation/No Show Policy

Appointment times are an important commitment of reserved time for you and your provider. Therefore, missed appointments create interruption for staff members and other patients on the schedule. We understand that personal matters do occur that may necessitate a cancellation; therefore, we ask kindly for at least a 24-hour advance notification. Cancellations that are made on the day of the appointment fall into the category of "no-show." Patients who fail to present for a scheduled appointment without contacting the office to cancel the appointment within 24 hours are considered a "no-show." Integrative Medical Solutions reserves the right to bill the patient \$75.00 after the first "no show" appointment and any thereafter. IMS also reserves the right to discharge the patient from the practice due to the chronic "no-show" of the patient. This decision will be made by the patient's responsible provider. In addition, the patient will not be seen until the balance on account is paid.

Initial

Authorization for release of protected health information

I hereby authorize Integrative Medical Solutions to release information contained in my medical record including information regarding scheduled appointments, medications, and/or billing on my account to the following individuals:

Name / relationship: _____

Name / relationship: _____

Name / relationship: _____

Name / relationship: _____

May we leave medical information, test results, etc. on your voicemail and or text you? No Yes

Initial

By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction.

Initial

I attest that all the information on these intake forms are accurate and true to the best of my knowledge:

Patient Name (printed) _____

Patient DOB _____

Patient Signature _____

Date _____