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: ______________________

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(S)/FORMS, DRIVERS LICENSE AND SOCIAL SECURITY 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) ______________________

Medicare Lifetime Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any Medical costs not covered by Medicare.

______________________ ______________________ ____________

Patient Signature Medicare Number Date

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

EYES, EARS, NOSE, THROAT

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

SKIN

- ☐ Actinic Keratosis
- ☐ Psoriasis
- ☐ Eczema

ENDOCRINE

- ☐ 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:

PREGNANCIES

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

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 __________

CURRENT MEDICATIONS (use back of page if needed)

	Dose	Taken (ie times per day)

SUPPLEMENTS / VITAMINS / HERBS

	Dose	Taken

SURGERIES

	Date	Surgeon

FAMILY HISTORY

"X" in appropriate boxes to identify conditions in your blood relatives					Mother's Mother	Mother's Father	Father's Mother	Father's Father	If Deceased, cause of death and age
Illness/Condition	Father	Mother	Sister(s)	Brother(s)					
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_______________