Adult New Patient Intake Form

Patient Information

Shaded area very important: Please list two phone numbers and Social Security number.

Last Name: _____ First Name: _____ DOB: _____

Home Phone: _____ Mobile Phone: _____ SSN: _____

Address: _____

Preferred (circle): Home / Cell Email: _____ Gender: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Primary Care Provider (PCP): _____ Pharmacy: _____

Referring Provider (who sent you to us?): _____

Please list ALL active treating physicians (i.e., pulmonologist, oncologist, internist, cardiologist, etc.)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

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:
□ Decline Response
□ Hispanic or Latino
□ Not Hispanic or Latino

Race:
□ Decline Response
□ American-Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Pacific Islander
□ White
□ Other

Preferred Language: _____ □ Decline Response

___ I have read, understand and agree to the Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

___ I authorize my insurance benefits be paid directly to **NRMC ENT**. In the event my claim is denied, I authorize **NRMC ENT** to file an appeal on my behalf.

___ In order to properly treat me, I authorize **NRMC ENT** permission to view my prescription medication records.

___ I authorize **NRMC ENT**, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

___ I authorize **NRMC ENT** to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

___ I also understand that certain procedures and tests performed in this office are not included in the standard office visit. Some of the procedures are classified as "surgery" by my insurance carrier and that the charges may go towards my deductible. This includes, but is not limited to, flexible laryngoscopy, nasal endoscopy, cerumen removal and audiometric testing.

___ I understand that a missed appointment is when I fail to show up for an appointment, cancel less than 24 hours prior to your scheduled appointment, or arrive more than 15 minutes late. After my third missed appointment, I understand that I
will be discharged from the clinic.

___ I acknowledge that I was given the opportunity to obtain a copy of **NRMC ENT's** privacy practices.

___ I authorize **NRMC ENT** to contact or discuss my personal health information with:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

Medical and Social History

Reason for today's visit: _____

_____

General Medical Questionnaire

Have you EVER had any of the following?

Arthritis.....□ Y □N
Asthma/Breathing problems .....□ Y □N
Bleeding/Clotting Disorder.....□ Y □N
Blood Pressure Disorder..... □ Y □N
Blood Transfusion.....□ Y □N
Bowel/Stomach problems .....□ Y □N
Cancer/Leukemia .....□ Y □N
Cholesterol Disorder.....□ Y □N
Diabetes .....□ Y □N
Eye Disorder (i.e., Glaucoma, Cataract).....□ Y □N
Women Only: Gynecological Issues..... □ Y □N
Heart disorder/defect .....□ Y □N
Lung Disorder..... □ Y □N
Liver disease .....□ Y □N
Neurological Disorder/Chronic Headaches..... □ Y □N
Psychiatric Disorder/Illness .....□ Y □N
Pulmonary Embolism/DVT.....□ Y □N
Stroke.....□ Y □N
Seizure or Epilepsy.....□ Y □N
Thyroid Disorder.....□ Y □N
Urinary/Kidney Disorder.....□ Y □N

Please provide details for any of the above conditions answered "yes" or any other conditions not mentioned:

_____
_____
_____
_____

Do you have any allergies to medications or other substances (pets, plants, food, etc.)? □ Y□ N
If yes, please list allergies and reactions (including rash, hives, throat swelling anaphylaxis):

Allergy	Reaction

Please list any past surgeries and hospitalizations and the approximate date.

Procedure/Hospitalization	Date	Reason	Complications

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Do you smoke? □Y □N □Never If Y, Packs/day _____ If N, previously? □Y □N Yrs. smoked _____ Packs/day _____

Do you use other tobacco products? □Y □N Consume alcohol? □Y □N If Y, drinks/week _____

Do you use street drugs? □Y □N If Y, what? _____

If N, previously? □Y □N and what? _____

Women Only: Any past pregnancies? □Y □N How many? _____ How many deliveries? _____

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

□ I don't know my medications.

Medication Name	Dose

OFFICE USE ONLY:

Provider Signature: _____ Date: _____

Natchitoches Regional Medical Center
Inspiring Excellence Everyday