APEX MEDICAL CENTER

PATIENT INTAKE FORM

PATIENT INFORMATION

Name:____ Soc. Sec. #: ____________________

Last Name First Name Initial

Address: ____

City:____ State: ______________ Zip: ______________

Sex: ☐ M ☐ F Age: ________ Birth date: ______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By:____________________________________ Occupation: ____________________

Home Phone: __________________________ Work/Mobile Phone: ____________________________

Whom may we thank for referring you? ____

In case of emergency, who should be notified? __________________________ Phone: ____________________

PRIMARY INSURANCE

Person Responsible for Account: ____

Last Name First Name Initial

Relationship to Patient: ____________________ Birth date: ______________ Soc. Sec #: ________________

Address (if different from patient's): ______________________________ Phone: ______________________

City:____ State: ______________ Zip: ______________

Person Responsible Employed by: ______________________________ Occupation: ______________________

Business Address: __________________________________ Business Phone: ______________________

Insurance Company:____________________________________ Ins. ID#: __________________________

Names of other dependents covered unde this plan: ____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: ____________________ Relation to Patient: ____________________ Birth date: ______________

Address (if different from patient's): ______________________________ Phone: ______________________

City:____ State: ______________ Zip: ______________

Subscriber Employed By:____________________________________ Occupation: ____________________

Insurance Company: ____________________________________ Ins. ID#: __________________________

Names of other dependents covered unde this plan: ____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________________

Name of Insurance Company(ies)

and assign directly to my provider all insurance benefirs otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

______________________________ ______________________ ______________

Responsible Party Signature Relationship Date

I give permission for treatment of myself/my dependent to my assigned provider.

______________________________ ______________________ ______________

Responsible Party Signature Relationship Date

APEX MEDICAL CENTER

PATIENT HISTORY

HOSPITALIZATION HISTORY

1. ____________________ DATE: __________
2. ____________________ DATE: __________
3. ____________________ DATE: __________

SURGICAL HISTORY

1. ____________________ DATE: __________
2. ____________________ DATE: __________
3. ____________________ DATE: __________

MVA/INJURY HISTORY

1. ____________________ DATE: __________
2. ____________________ DATE: __________
3. ____________________ DATE: __________

SOCIAL HISTORY

Do you Smoke? ☐ Yes ☐ No How Long? __________ How Much? __________

Do you drink alcoholic beverages? ☐ Yes ☐ No How Long? __________ What? __________

Do you take recreational drugs? ☐ Yes ☐ No How Long? __________ What? __________

CURRENT MEDICATIONS

Please list your medication(*including over the counter and herbal supplements*) you may provide a list to the nurse:

Name/Dose/Quantity

1. ____________ / ________ / ____________
2. ____________ / ________ / ____________
3. ____________ / ________ / ____________
4. ____________ / ________ / ____________
5. ____________ / ________ / ____________
6. ____________ / ________ / ____________
7. ____________ / ________ / ____________
8. ____________ / ________ / ____________
9. ____________ / ________ / ____________

ALLERGIES

Medication/Reaction

1. ____________ / ____________
2. ____________ / ____________
3. ____________ / ____________
4. ____________ / ____________

Food/Reaction

1. ____________ / ____________
2. ____________ / ____________
3. ____________ / ____________
4. ____________ / ____________

Patient Name: ____________________ Pt. Signature: ____________________ Date: __________

APEX MEDICAL CENTER

PATIENT HISTORY

REVIEW OF SYSTEM

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Weight loss
- ☐ Decline In Health
- ☐ Weakness
- ☐ Fatigue
- ☐ Weight gain

Head
- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Pain
- ☐ Head Injury
- ☐ Sweats

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Eyeglass use
- ☐ Pain with light
- ☐ Unusual Sensations
- ☐ Cataracts
- ☐ Excessive Tearing
- ☐ Glaucoma
- ☐ Recent Injury
- ☐ Vision Loss
- ☐ Discharge
- ☐ Eye Pain
- ☐ Infections
- ☐ Redness

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pleurisy
- ☐ Short of Breath
- ☐ Cough
- ☐ Coughing Blood
- ☐ Positive TB Test
- ☐ Sputum
- ☐ Wheezing
- ☐ Pain
- ☐ Recent Chest X-Ray
- ☐ Tuberculosis

Allergic/Immunologic
- ☐ Coughing
- ☐ Itchy Eyes
- ☐ Runny Nose
- ☐ Watery Eyes
- ☐ Coughing with Exercise
- ☐ Itchy Nose
- ☐ Sneezing
- ☐ Wheezing
- ☐ Hives
- ☐ Recurrent Infections
- ☐ Coughing
- ☐ Coughing

Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rashes
- ☐ Other ______________

Cardiovascular
- ☐ Chest Pain
- ☐ Extremity(s) Cool
- ☐ Heart Murmur
- ☐ History of Heart Attack
- ☐ Rheumatic Fever
- ☐ Short of Breath - Sleeping
- ☐ Ulcers on Legs
- ☐ Palpitations
- ☐ Extremity(s) Discolored
- ☐ Heart Tests (Not EKG)
- ☐ Leg Pain - Walking
- ☐ Short of Breath - Exertion
- ☐ Varicose veins
- ☐ Swelling of Legs
- ☐ High Blood Pressure
- ☐ Recent Electrocardiogram
- ☐ Short of Breath - Lying Flat
- ☐ Thrombophlebitis
- ☐ Diarrhea
- ☐ Liver Disease
- ☐ Antacid use
- ☐ Change in Stool Caliber
- ☐ Decreased Appetite
- ☐ Gallbladder Disease
- ☐ Infections
- ☐ Rectal Pain
- ☐ Vomiting Blood

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Rectal Bleeding
- ☐ Black Tarry Stools
- ☐ Change in stool color
- ☐ Excessive Hunger
- ☐ Hemorrhoids
- ☐ Laxative Use
- ☐ Swallowing Problem
- ☐ Constipation
- ☐ Jaundice
- ☐ Abdominal X-Ray Tests
- ☐ Change in frequency of BM
- ☐ Change in stool consistency
- ☐ Excessive Thirst
- ☐ Hepatitis
- ☐ Nausea
- ☐ Vomiting

Psychiatric
- ☐ Depression
- ☐ Disturbing Thoughts
- ☐ Memory Loss
- ☐ Psychiatric Disorder
- ☐ Behavioral Change
- ☐ Excessive Stress
- ☐ Mood Changes
- ☐ Disorientation
- ☐ Hallucinations
- ☐ Nervousness
- ☐ Head Injury

Musculoskeletal
- ☐ Arthritis
- ☐ Back Problems
- ☐ Muscle Cramps
- ☐ Restricted Motion
- ☐ Joint pain
- ☐ Deformities
- ☐ Muscle Stiffness
- ☐ Weakness
- ☐ Gout
- ☐ Joint Stiffness
- ☐ Paralysis

Hematologic/Lymoh
- ☐ Anemia
- ☐ Easy Bruisability
- ☐ Swollen Glands
- ☐ Bleeding Easily
- ☐ Lumps
- ☐ Transfusion Reaction
- ☐ Blood Clots
- ☐ Radiation Exposure

Neurological
- ☐ Loss of Consciousness
- ☐ Dizziness
- ☐ Headaches
- ☐ Paralysis
- ☐ Speech Disorders
- ☐ Blackouts
- ☐ Fainting
- ☐ Memory Loss
- ☐ Other ______________

PAST MEDICAL HISTORY/FAMILY HISTORY

	SELF	FAMILY		SELF	FAMILY
TB	☐	☐	Kidney Problem	☐	☐
Heart Problem	☐	☐	Asthma/Allergies	☐	☐
Diabetes	☐	☐	Cancer	☐	☐
Liver Disease	☐	☐	Emphysema	☐	☐
Multiple Sclerosis	☐	☐	Stroke	☐	☐
Hypertension	☐	☐	Thyroid Problem	☐	☐
Epilepsy	☐	☐	Bowel Disorder	☐	☐
Seizure	☐	☐	Colitis	☐	☐
Anemia	☐	☐	Gall Bladder	☐	☐
Phlebitis	☐	☐	HIV/AIDS	☐	☐
Hepatitis	☐	☐	Other ____________________	☐	☐

Patient Name: ____ Pt. Signature: ________________________ Date: ______________