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Before your first visit:

- **Call your health insurance company and list Northeast Medical, PC or the provider you are scheduled to see as your new Primary Care Physician (PCP) as some insurance companies require this.**
- **A medical record release has been enclosed for your convenience, or, if you prefer, you may contact your current primary care physician's office directly to request that your records be transferred to our office.**
- **Please complete the enclosed New Patient forms and consent forms.**

Please Note: Failure to return the complete patient information forms, and failure to update your PCP will result in the automatic cancellation of your new patient appointment. We thank you in advance for your cooperation regarding this policy.

On your first visit, please bring:

- 1. Your current insurance card**
- 2. Your co-pay/co-insurance if applicable. We accept cash, check, Visa, MasterCard, Discover, and American Express.**
- 3. Government-issued photo ID**
- 4. All medication bottles**

Please arrive 20 minutes prior to your scheduled appointment time. If you need to cancel your appointment for any reason, please allow a minimum of 24 hours' notice.

WELCOME!

Today's Date: _____

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____ SSN#: _____

Date of Birth: _____ Age: _____ Sex: _____ Gender Identity: _____ Sexual Orientation: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email Address: _____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

Race: _____ Ethnicity (Circle One): Hispanic/Non-Hispanic Primary Language: _____

Street Address: _____ Mailing Address (If Different): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Employer/Occupation: _____

ACCOUNT RESPONSIBILITY (If different than above)

Who is responsible for this account? _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Cell Phone: _____ Home Phone: _____ Date of Birth: _____ SSN #: _____

MEDICAL INSURANCE

Name of Primary Insurance Company: _____

Subscriber Name: _____ Group # _____

Member ID: _____ Subscriber Date of Birth: _____

Name of Secondary Insurance Company: _____

Subscriber Name: _____ Group # _____ Member ID: _____

Subscriber Date of Birth: _____ Medicare ID (If on Medicare): _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Northeast Medical, P.C. to release any information required to process my claims.

Patient/Guardian signature

Date

Chief Complaint: What is the reason for your visit today? (Please describe problem in detail including history of present illness):

Name/address/phone # of Pharmacy:

Social History:

Marital Status (Circle One): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Average per day:

Alcohol _____ Tobacco (Packs Per Day) _____ Years _____

Caffeine _____ Recreational Drugs _____

Current Diet (Circle One): Diabetic Low Fat Other _____

Exercise Type: _____ Frequency: _____

Medical History:

Medications	Diagnosis/ Reason for medication	Specialist/prescriber?

Implanted medical devices, or other medical devices i.e. CPAP, Oxygen:

Prior Hospitalizations & Illnesses:

Allergies (Medications, Food, Environmental) AND description of reaction:

Vaccines	Year	Screenings	Year	Other Tests	Year
Flu		Colonoscopy		DEXA Scan	
Tetanus (Tdap)		Mammogram		Stress Test	
Pneumonia		Pap Smear		Other:	
Shingles		Eye Exam			

Surgical History:

Surgery	Year	Specialist

Family History:

Diagnosis	Relative (Specify Paternal or Maternal)	Age at Diagnosis
Cardiac (heart attack, stroke,)		
High Blood Pressure		
Cancer (specify type)		
Diabetes		
Mental Health		
Other		

Have you had any of the following issues IN THE LAST 3 MONTHS?

Systemic:	weight change, fevers, fatigue
Head:	headache, sinus pain
Eyes:	vision change, redness, pain
Neck:	pain, muscle tightness, lumps
Breast:	lumps, pain, skin change
Neurological:	dizziness, fainting, confusion, numbness or tingling
Musculoskeletal:	muscle aches, joint pain, weakness
Hematological:	bruising, easy bleeding, anemia
Psychological:	depression, anxiety, trouble sleeping
Genitourinary:	change in urine, incontinence, genital discharge
Gastrointestinal:	vomiting, diarrhea, constipation, blood in stool, stomach pain
Cardiovascular:	chest pain, racing heart, fainting, palpitations
Pulmonary:	shortness of breath, wheezing, cough
Ears/Nose/Throat:	sore throat, stuffy nose, snoring, sneezing
Endocrine:	excessive thirst, hair loss, excessive sweating
Skin:	rash, itching, sores

WOMEN ONLY

Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, number of times:		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Have you noticed a decrease in urination strength?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No