Name _____ Date of Birth _____

Patient Intake Form

Please fill out this form to the best of your knowledge. Your answers help us plan and provide your care.

Personal Information

Address: _____

Zip Code: _____ **City:** _____ **State:** _____ **Age:** _____ **Sex:** ○ Male ○ Female

Email: _____

Primary Language: _____ **Race**: _____ **Occupation** _____

Home Number: _____ **Mobile Number:** _____

Marital Status _____ **Referring Physician**: _____

PCP: _____ **Last Seen Date:** _____

Pharmacy Information

Pharmacy Name: _____ **Address:** _____

Zip Code: _____ **City:** _____ **Phone:** _____

Reason we are seeing you today:

_____

Medical Insurance Info: _____ ID: _____

Secondary Ins: _____ ID: _____

If Workers Comp Insurance please provide us with your Adjustors Information, Claims #, and Date of Accident:

_____

_____

_____.

Current Prescriptions *(list all medications you are taking at present)*

Medication name Dosage/ Route	How often
Example: Lasix 20 mg, PO	Daily

Any medication allergies? _____

Name _____ Date of Birth _____

Mental Health

Over the last 2 weeks, how many bad days have you had:	
Had little interest or pleasure in doing things?	
Felt down, depressed or hopeless?	

Past Medical History (*check all that apply)*

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clot (DVT/PE)
- ☐ Coronary artery disease (Heart attack)
- ☐ COPD/emphysema
- ☐ Cancer/History of cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure

above:

- ☐ Depression
- ☐ Diabetes Type I/II
- ☐ GERD
- ☐ Hepatitis (type ___)
- ☐ Hypertension (High blood pressure)
- ☐ Hyperlipidemia (High cholesterol) Migraine
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Please list any other conditions not mentioned

Past Surgical History *(check all procedures that apply)*

- ☐ Appendectomy
- ☐ Coronary artery bypass (open heart)
- ☐ Gastric bypass
- ☐ Hysterectomy (removal of uterus)
- ☐ Joint repair/replacement (i.e hip,knee,shoulder)
- ☐ Nephrectomy (removal of kidney)
- ☐ Spinal surgery
- ☐ Splenectomy (removal of spleen)

Please list any other procedures not mentioned above: _____

Social History Yes/ How much or often	No
Do you smoke tobacco?	
Do you drink alcohol?	
Have you ever struggled with addiction? If yes, have you been sober?	

Name _____ Date of Birth _____

Family History (*please indicate first degree relatives only)*

- ☐ Anemia
- ☐ Asthma
- ☐ Blood clot (DVT/PE)
- ☐ Coronary artery disease (Heart attack)
- ☐ COPD/emphysema
- ☐ Cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Dementia
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypertension (High blood pressure)
- ☐ Hyperlipidemia (High cholesterol)
- ☐ Osteoporosis
- ☐ Seizure
- ☐ Skin condition
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Would you be interested in learning more about *(check all that apply)***:**

- ☐ Botox Injections
- ☐ Foot and ankle care/ peripheral
- ☐ Neuropathy
- ☐ IV therapy (fluid hydration, vitamins)
- ☐ Skin care products

Anything else you would like to share with the provider? _____

_____

How did you hear about us? _____

Extended Auth

I hereby authorize Music City Primary Care, PLLC to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Music City Primary Care, PLLC all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for any payment if I have not fulfilled their requirements. I also acknowledge the receipt of HIPAA privacy policy.

Signature: _____ **Date**: _____

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Music City Primary Care, PLLC and/or his designees.

Signature: _____ **Date:** _____