integrative medical solutions

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's	Father's	Father's	If Deceased, cause of
Illness/Condition	Father	Mother	Sister(s)	Brother(s)	Mother	Father	Mother	Father	death and age
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

Patient name_____ DOB_____

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 will be considered a "no-show." Integrative Medical Solutions reserves the right to bill the patient $75 after the second "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? No Yes

_____
Initial

Patient Portal Authorization Agreement

Integrative Medical Solutions offers secure electronic access to your medical record and secure electronic communication, including appointment requests, for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation. You may review the privacy policy for e-MD's patient portal at www.healthportalsite.com at the bottom of the web page under "e-MD's Privacy and Terms."

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_____