Broad Top Area Medical Center, Inc.
4133 Medical Center Drive PO Box 127
Broad Top, PA 16621 – 9001

Due to the complexity of the medical insurance industry, it is important that we know whether you have an existing doctor. These physicians are often referred to as your PCP Primary Care Provider. For many insurance plans, he or she is the only provider who can approve of you receiving non-emergency care for things such as office visits, X-rays, lab tests, cardiac stress tests, colonoscopy, and referrals to specialists, etc. If we see you for non-emergency care and order such things without PCP approval, you would then be billed personally for the costs. By signing this statement, you acknowledge this responsibility. Your signature also indicates that you have no other PCP.

Clinical Intake Information

Broad Top Area Medical Center, Inc. utilizes physician, nurse practitioner, and physician assistant providers. When scheduling your new patient appointment, we must know your past medical history, medications, and current problem to determine which type of provider can best meet your needs. For this reason, we ask you to provide the following information. Be advised, there is no guarantee or assurance that our provider will determine the continued need for or initiation of a controlled substances as part of your management plan.

List All Prior Medical Providers: _____

_____

List Current Medical Problem: _____

Medical Problems – Past & Present

Problem	Yes	No	Problem	Yes	No
Back Pain			*Cancer*		
Nerve Pain			*Migraine/Headaches*		
Muscle Aches and Pain			*Other Cause of Chronic Pain*		
Arthritis/Joint Problems			*Learning or Attention Problem*		
High Blood Pressure			Heart Problem		
Strokes			High Cholesterol		
Diabetes/Sugar			Seizure/Convulsion		
Asthma			Lung Problem		
Liver Problem			Reflux or Stomach Problem		
Thyroid Problem			Kidney Problem		
Eye Problem					

List All Prior Surgeries: _____

_____

List All medications, both prescription and over the counter drugs: (add pages if needed)

_____

_____

_____

_____

PRINT NAME: BIRTH DATE:

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

PATIENT SIGNATRE: DATE: