

Instructions:

- Step 1 – Print this PATIENT INTAKE FORM and fill it out
- Step 2 – Scan and email it to us or fax it to us or bring it with you to your appointment
- Step 3 – Call 719-687- 6088 Monday – Friday from 12pm to 6pm to schedule your appointment

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**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Today's Date** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City, State, Zip** \_\_\_\_\_ **Home Phone #** \_\_\_\_\_  
**SSN** \_\_\_\_\_ **Pharmacy Preference** \_\_\_\_\_  
**Email Address** \_\_\_\_\_  
**Insurance Co** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_  
**Policy Holder** \_\_\_\_\_ **SSN** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**Patient's Relationship to Policy Holder:** Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_

**EMERGENCY CONTACTS**

**Name** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_ **Home/Cell** \_\_\_\_\_  
**Name** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_ **Home/Cell** \_\_\_\_\_

**SOCIAL HISTORY**

**Relationship status:**  Single  Married  Partnered  Separated  Divorced  Widowed  
**Birthplace** \_\_\_\_\_ **Education/Degree** \_\_\_\_\_  
**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**ALLERGIES**

**LIFESTYLE CHOICES**

**Exercise** Type \_\_\_\_\_ **Times per week** \_\_\_\_\_ **Duration** \_\_\_\_\_  
**Alcohol** Drinks per week? \_\_\_\_\_ For how long? \_\_\_\_\_  
**Caffeine** Cola \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ **Drinks per day** \_\_\_\_\_  
**Smoking** If yes: Age you started? \_\_\_\_\_ Age you quit? \_\_\_\_\_ How much per day? \_\_\_\_\_

**MEDICATIONS, VITAMINS, SUPPLEMENTS** Circle the following non-prescription items that you use:

- |               |                           |                        |
|---------------|---------------------------|------------------------|
| Acetaminophen | Ibuprofen (Advil, Motrin) | Supplements            |
| Allergy Pills | Laxatives                 | Vitamins (Please list) |
| Antacids      | Naproxen (Aleve)          | Herbs (Please list)    |
| Aspirin       | Nasal Sprays              |                        |
| Decongestants | Natural Hormones          |                        |

Please list your prescription and dosages of medications you take: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PREVENTIVE SERVICES**

Last Physical \_\_\_\_\_ Physician \_\_\_\_\_

List the **AGE** you last had these services or tests.

**Screening**

Mammogram \_\_\_\_\_  
 Pap smear \_\_\_\_\_  
 Colonoscopy \_\_\_\_\_  
 Prostate check \_\_\_\_\_  
 Bone Density \_\_\_\_\_

**Health Maintenance**

Dentist Visit \_\_\_\_\_  
 Eye exam \_\_\_\_\_

**Immunizations**

Last Tetanus \_\_\_\_\_  
 Shingles shot \_\_\_\_\_  
 Pneumonia shot \_\_\_\_\_  
 HPV \_\_\_\_\_  
 Flu \_\_\_\_\_

Specialists you are seeing \_\_\_\_\_

**MEDICAL HISTORY/SURGERIES:**

Please list medical history and any surgeries you may have had, along with **AGE** at time of service:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

Tell us about your **immediate family** members:

Check here  if you were ADOPTED

Family Member	Birth Year	Health Status	If Deceased	
			Age at Death	Cause
Father				
Mother				
1. Brother/Sister <i>(circle one)</i>				
2. Brother/Sister				
3. Brother/Sister				
Spouse				
1. Son/Daughter <i>(circle one)</i>				
2. Son/Daughter				
3. Son/Daughter				

**MENSTRUAL HISTORY** First date of last period \_\_\_\_\_ If menopausal, age at last period \_\_\_\_\_

Periods irregular?     Yes  No    How many pregnancies \_\_\_\_\_ Number of children born alive \_\_\_\_\_

Birth Control:         Pills  Condoms  IUD  Surgery  Other \_\_\_\_\_

Circle any of the following symptoms you've had in the **last 2 weeks.**

**General**

loss of appetite  
weight loss  
chills  
fevers  
sweats  
fatigue  
sleep disorder

**Eyes**

blurred vision  
double vision  
vision loss or blindness  
discharge  
redness  
eye pain  
yellow eyes

**Ear/Nose/Throat**

ear drainage  
earaches  
hearing loss  
ear ringing  
nose bleeds  
snoring  
sore throat  
hoarseness

**Endocrine**

urinating a lot  
drinking a lot  
poor wound healing  
temperature intolerance  
hot flashes

**Cardiovascular**

chest pain or pressure  
swelling in feet  
calf pain with walking  
irregular heart beats  
palpitations  
fainting  
lightheadedness

**Respiratory**

cough  
sputum  
short of breath  
coughing blood  
pleurisy  
wheezing

**Gastrointestinal**

abdominal pain  
difficulty or painful  
swallowing  
indigestion  
nausea  
vomiting  
diarrhea  
constipation  
change in bowel habits  
black tarry stool  
blood in stools  
jaundice

**Blood/Lymph**

bleeding  
easy bruising  
swollen lymph nodes

**Genito-urinary**

decreased stream  
painful urination  
frequency  
blood in urine  
getting up to urinate at  
night  
urinary incontinence  
abnormal menstrual  
periods  
vaginal discharge  
pelvic pain  
genital lesions  
penile discharge  
erectile dysfunction

**Musculoskeletal**

joint pains  
joint swelling  
stiff joints  
neck pain  
back pain  
muscle cramps  
muscle weakness

**Neurological**

balance problems  
difficulty walking  
frequent falls  
dizziness  
headaches  
memory problems  
numbness  
seizures  
tremor  
weakness

**Breast**

lump  
tenderness  
nipple discharge

**Skin**

changed mole  
hair changes  
itchy skin  
rash  
skin color change

**Allergic**

anaphylaxis  
hay fever  
hives

**Psychiatric**

abusive relationship  
anxiety  
depression  
mood swings  
behavior problems  
confusion  
memory problems  
excessive alcohol  
consumption  
illegal drug usage  
hallucinations  
paranoia  
school difficulties  
separation anxiety  
sexual difficulty  
sleep disturbance  
suicidal thoughts

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of medical and surgical benefits to Richard Y. Harris, MD for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Richard Y. Harris, MD to release any medical or incidental information that may be necessary for either medical care, or in processing applications for financial benefit.

**MEDICARE/MEDICAID**

I certify that the information given by me in applying for payment is correct and authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

**A photocopy of these assignments shall be as valid as the original.**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
(Please Print)

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
(Please Print)

SIGNATURE \_\_\_\_\_

**HIPAA PRIVACY POLICY PATIENT CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my Treatment).
- Obtaining payment from third party payers (I.E, my insurance company).
- The day to day healthcare operation of your practice.

I have also been informed of and given the right to review and source a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Print Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Information can be released to:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_