PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of Xpedited Care. This form is used to collect information about new patients and is used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

First Name: _____ **Last Name**: _____

Date of Birth: _____ **Gender**: ☐ Male ☐ Female

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Home Phone: _____ **Mobile Phone**: _____

Social Security Number: _____ **E-Mail**: _____

Ethnicity/Race: _____ **Primary Language**: ☐ English ☐ Spanish ☐ Other:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name: _____ **Spouse Phone**: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship/ Phone: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ **ID #**: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are ***NOT*** the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

Policyholder Social Security Number: _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ **ID #**: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are ***NOT*** the policyholder for your secondary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

Policyholder Social Security Number: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose:** _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____

MEDICAL HISTORY

Do you currently have any medical conditions that you are being treated for? Please list:

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date**: _____

Print Name: _____