NEW PATIENT SCREENING FORM

Name:_____ Age:_____ Date of Birth: _____
Address: _____
Phone Number: _____ Alternate Phone Number:_____
Name of Insurance:_____ ID Number:_____
Current Primary Care Physician:

Specialists-seen within the past 2 years (Cardiologist, Pulmonologist, etc):
_____

_____

Current Medications:

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Current Pharmacy:

Local: _____ Mail order: _____

Medical Problems (circle):
Hypertension Diabetes Heart Disease
Stroke (CVA) Chronic Pain Peripheral vascular disease (PVD)
Anxiety Depression
Cancer (list type):_____
Other Medical Problem (list):_____

Surgeries (Circle):
None Appendectomy Tonsillectomy Cholecystectomy (gallbladder) Hysterectomy: Total or Partial
Joint replacement (circle joint and side): Hip L/R Knee L/R Shoulder R/L
Cardiac Surgery: CABG / Stent
Other (Please List): _____
Reason for appointment: Establish Care Medication Refills
Other (please explain):

_____

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Acknowledgement:

Please carefully read and initial each section of this form. By initialing and signing this form you agree with the terms listed on this form.

_____ I understand that Complete Health Care is not currently accepting any patients that are requiring care for chronic pain. If I am accepted by this practice I understand the physicians/practitioners will NOT prescribe any pain medications for me.

_____ I understand that if I am currently taking any pain medications on a routine basis I will need to be seen by a Pain Management Specialist for these medications to be continued. I also understand that this office will NOT prescribe any controlled medications while I am waiting to be seen by pain management.

_____ In anticipation of a potential change in health care, I give Complete HealthCare authorization to obtain information from my current healthcare provider, pharmacy, and/or state pharmacy database to review my current health status.

_____ I understand that if I am accepted by Complete HealthCare and scheduled to see one of the providers in this practice, I will not be under the physician's care until I am actually seen in the office. If I need any medication refills or urgent care before I am seen in the office I will need to see my current primary care doctor or local ER for treatment.

_____ I understand that completing and submitting this paperwork does NOT guarantee that I will be accepted as a patient by this practice. I further understand that filling out and submitting this form does not constitute a doctor-patient relationship, and does not entitle me to refills, visits, or care by Complete HealthCare.

Signature: _____ Date: _____

Printed Name:_____

INTERNAL USE ONLY

Date Received:_____ Initial:_____ Date Reviewed:_____ Initial: _____

Action:

Accepted- _____

Denied:

_____ Condition(s) exceeds our scope of practice

_____ Discrepancy on screening history or data

_____ High Risk – recommend specialty care

_____ Other: _____

Patient Notified:

Date:_____ Appt date/time: _____Provider: _____ Initial:_____