

LILIYA GERSHENGOREN MD

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Intake Form

(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit.

Name: _____ Birthdate: _____

Address: _____ zip code: _____

Cell Phone: _____ Other Phone: _____ Email: _____

Primary Care Physician: _____ Phone: _____

Other Physicians (please list specialty): _____ Phone: _____

Mental Health Providers (if applicable): _____ Phone: _____

How did you hear about me? Name of individual who referred you if applicable: _____

Emergency Contact:

Name: _____ Relationship to You: _____

Emergency Contact's Tel Number: _____ Email Address: _____

Preferred Pharmacy:

Name: _____ Address: _____ zip code: _____

Tel Number: _____ Fax Number: _____

Insurance Information:

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Relationship to patient: _____ Policy Holder's Tel: _____

Insurance Company: _____

ID Number: _____ Group Number: _____

Member Service's Tel Number on the Back of Card: _____

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Medical History:

Allergies: _____

Current medical problems: _____

Past medical problems, hospitalizations or surgeries:

Have you ever had an EKG? () Yes () No If yes, when? _____

What was the EKG result? () Normal () Abnormal () Unknown

Date and place of last physical exam: _____

For women only: Date (or age if postmenopausal) of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? () Yes () No

Are you planning to get pregnant in the near future? () Yes () No

List ALL current prescription medications and how often you take them:

<i>Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>Indication</i>
Ex: Aspirin	81mg	In the morning	Heart disease

Current over-the-counter medications or supplements:

Family Medical / Psychiatric History:
