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: _____

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: _____

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:

Name	*Dose*	*Frequency*	*Indication*
Ex: Aspirin	81mg	In the morning	Heart disease

Current over-the-counter medications or supplements:

_____

_____

Family Medical / Psychiatric History:

_____

_____

_____