Tallapoosa First Response Patient First

Adult New Patient Intake Form

Patient Information

Last Name: ____________________ First Name: ____________________ DOB: ________________

Legal Sex*: ___ Home Phone: ________________ Mobile Phone: ____________________

Preferred Phone: Home or Mobile (circle one) Email: ______________________

Emergency Contact/Relation: ____________________ SSN: ______________________________

Emergency Contact Phone: ______________________ Patient Marital Status: ______________________

Occupation: ________________________________ Employer: ______________________________

Primary Care Provider (PCP): ______________________________ PCP Phone: ________________

Referring Provider: ______________________________________ Referring Phone: ______________

Preferred Pharmacy: ____________________________________ Pharm Phone: ________________

Preferred Pharmacy Address: ____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name: ____________________________ Specialty: ____________________________________

Doctor's Name: ____________________________ Specialty: ____________________________________

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Doctor's Name: ____________________________ Specialty: ____________________________________

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
- ◻ Decline Response
- ◻ Hispanic or Latino
- ◻ Not Hispanic or Latino

Race:
- ◻ Decline Response
- ◻ American-Indian or Alaska Native
- ◻ Asian
- ◻ Black or African American
- ◻ Native Hawaiian or Pacific Islander
- ◻ White
- ◻ Other

Preferred Language: ◻ Decline Response

Patient Financial Obligation Agreement

I authorize my insurance benefits be paid directly to Tallapoosa First Response for services rendered. I authorize representatives of Tallapoosa First Response to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the Tallapoosa First Response Notice of Privacy Practices (NOPP).

◻ Received ◻ N/ A (only if you received the notice from Tallapoosa First Response previously)

Information Disclosure and Consent

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): ______________________________________

Patient or Legal Guardian Signature: ____ Date: ________________

Please be aware that the name and sex you have listed on your insurance

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems........................ ☐ Y ☐ N
Arthritis.. ☐ Y ☐ N
Bleeding/Clotting Disorder......................... ☐ Y ☐ N
Blood Pressure Disorder............................. ☐ Y ☐ N
Blood Transfusion .... ☐ Y ☐ N
Bowel/Stomach Problems........................... ☐ Y ☐ N
Cancer.. ☐ Y ☐ N
Cholesterol Disorder .... ☐ Y ☐ N
Diabetes... ☐ Y ☐ N
Eye Disorder (i.e. Glaucoma, cataract)......... ☐ Y ☐ N
If Relevant: Gynecological Issues............. ☐ Y ☐ N

Heart Disease/Disorder .... ☐ Y ☐ N
Lung Disorder.. ☐ Y ☐ N
Liver Disease .... ☐ Y ☐ N
Neurological Disorder/Chronic Headaches.. ☐ Y ☐ N
Psychiatric Disorder/Illness......................... ☐ Y ☐ N
Pulmonary Embolism/DVT .... ☐ Y ☐ N
Stroke.. ☐ Y ☐ N
Seizure or Epilepsy .... ☐ Y ☐ N
Thyroid Disorder .... ☐ Y ☐ N
Urinary/Kidney Disorder............................. ☐ Y ☐ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	

Do you currently smoke? ☐ Y ☐ N If no, previously? ☐ Y ☐ N Years smoked _______ Packs/day ________

Do you use other tobacco products? ☐ Y ☐ N Consume alcohol? ☐ Y ☐ N If yes, drinks/week: ________

If Relevant: Any past pregnancies? ☐ Y ☐ N How many? ___ How many deliveries? ____

Do you have any allergies to medications or other substances (pets, food, etc.)? ☐Y ☐N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

Constitutional

☐Y☐N Fever
☐Y☐N Chills
☐Y☐N Fatigue
☐Y☐N Feeling Poorly
☐Y☐N Sweats
☐Y☐N Weight Gain (___ Lbs)
☐Y☐N Weight Loss (___ Lbs)
☐Y☐N Unexp. Weight Change
☐Y☐N Sleep Disturbances
☐ Other:

Head, Eyes, Ears, Nose, and Throat

☐Y☐N Vision Problem
☐Y☐N Decreased Hearing
☐Y☐N Double Vision
☐Y☐N Light Sensitivity
☐Y☐N Itchy Eyes
☐Y☐N Red Eyes
☐Y☐N Eye Pain
☐Y☐N Runny Nose
☐Y☐N Neck Stiffness
☐Y☐N Nosebleed
☐Y☐N Congestion
☐Y☐N Snoring
☐Y☐N Dry Mouth
☐Y☐N Flu-Like Symptoms
☐Y☐N Sore Throat
☐Y☐N Hoarseness
☐Y☐N Ringing in Ears
☐Y☐N Vertigo
☐Y☐N Earache
☐Y☐N Other:

Cardiovascular

☐Y☐N Chest Pain
☐Y☐N Palpitations
☐Y☐N Leg Swelling
☐Y☐N Cold Extremities
☐Y☐N Cold Hands or Feet
☐Y☐N Leg Pain w/ Walking
☐Y☐N Irregular Heart Rhythm
☐Y☐N Other:

Respiratory

☐Y☐N Shortness of Breath
☐Y☐N Cough
☐Y☐N Rapid Breathing
☐Y☐N Wheezing
☐Y☐N Shortness of Breath
☐Y☐N Chest Congestion
☐Y☐N Coughing Up Blood
☐Y☐N Coughing Up Sputum
☐ Other:
☐

Gastrointestinal

☐Y☐N Abdominal Pain
☐Y☐N Blood in Stool
☐Y☐N Vomiting
☐Y☐N Nausea
☐Y☐N Constipation
☐Y☐N Diarrhea
☐Y☐N Black/Tarry Stools
☐Y☐N Decreased Appetite
☐Y☐N Yellow Skin
☐Y☐N Trouble Swallowing
☐Y☐N Change in Bowels
☐Y☐N Vomiting Blood
☐Y☐N Bowel Incontinence
☐Y☐N Rectal Pain
☐Y☐N Heartburn
☐Y☐N Painful Swallowing
☐ Other:

Neurological

☐Y☐N Headache	☐Y☐N Unsteady	☐Y☐N Numbness	☐Y☐N Tremor
☐Y☐N Dizziness	☐Y☐N Disorientation	☐Y☐N Tingling	☐Y☐N Memory Lapses/Loss
☐Y☐N Decreased Strength	☐Y☐N Confusion	☐Y☐N Seizures	☐ Other:
☐Y☐N Poor Coordination	☐Y☐N Burning Sensation	☐Y☐N Fainting (Syncope)	

Musculoskeletal

☐Y☐N Joint Pain	☐Y☐N Limb Pain	☐Y☐N Muscle Pain	☐ Other:
☐Y☐N Neck Pain	☐Y☐N Joint Swelling	☐Y☐N Muscle Weakness	
☐Y☐N Back Pain	☐Y☐N Muscle Cramps	☐Y☐N Leg Swelling	

Genitourinary

☐Y☐N Frequent Urination	☐Y☐N Pelvic Pain	☐Y☐N Painful Intercourse	☐Y☐N Heavy Period Bleeding
☐Y☐N Incontinence	☐Y☐N Nocturia	☐Y☐N Discharge- Vaginal	☐ Other:
☐Y☐N Urinary Urgency	☐Y☐N Itching- Genital	☐Y☐N Vaginal Bleeding	
☐Y☐N Painful Urination	☐Y☐N Change in Libido	☐Y☐N Irreg. Monthly Cycles	

Integumentary

☐Y☐N Rash	☐Y☐N Skin Wound	☐Y☐N Unusual Growth	☐Y☐N Skin Cancer
☐Y☐N Dry Skin	☐Y☐N Change in A Mole	☐Y☐N Itching	☐ Other:

Psychiatric

☐Y☐N Depression	☐Y☐N Anxiety	☐Other:

Hematologic/Lymphatic

☐Y☐N Easy Bruising	☐Y☐N Easy Bleeding	☐Y☐N Swollen Lymph Nodes	☐ Other:

Endocrine

☐Y☐N Excessive Thirst	☐Y☐N Heat Intolerance	☐Y☐N Changes- Skin
☐Y☐N Cold Intolerance	☐Y☐N Changes- Hair	☐ Other:

OFFICE USE ONLY: Provider Signature: ______________________________ Date: ______________