ColumbiaDoctors

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Preferred Phone: _____ Email: _____ Gender: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____ Patient Marital Status: _____
Occupation: _____ Employer: _____
Primary Care Provider (PCP): _____ PCP Phone: _____
PCP Address: _____
Referring Provider: _____ Referring Phone: _____
Referring Address: _____
Preferred Pharmacy: _____ Pharm Phone: _____
Preferred Pharmacy Address: _____

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 Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____
Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

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

Patient Name (Print): _____
Patient Signature: _____ Date: _____
If completed by a patient's personal representative, please print and sign below.
Representative (Print): _____ Relationship: _____
Representative Signature: _____ Date: _____

myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

☐ Send me an invitation to join myColumbiaDoctors.
Look for an email invite from noreply@followmyhealth.org and click the Registration link.

Reason for today's visit: _____

_____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	□ Y □ N	Heart Disease/Disorder	□ Y □ N
Arthritis	□ Y □ N	Lung Disorder	□ Y □ N
Bleeding/Clotting Disorder	□ Y □ N	Liver Disease	□ Y □ N
Blood Pressure Disorder	□ Y □ N	Neurological Disorder/Chronic Headaches	□ Y □ N
Blood Transfusion	□ Y □ N	Psychiatric Disorder/Illness	□ Y □ N
Bowel/Stomach Problems	□ Y □ N	Pulmonary Embolism/DVT	□ Y □ N
Cancer	□ Y □ N	Stroke	□ Y □ N
Cholesterol Disorder	□ Y □ N	Seizure or Epilepsy	□ Y □ N
Diabetes	□ Y □ N	Thyroid Disorder	□ Y □ N
Eye Disorder (i.e. Glaucoma, cataract)	□ 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: _____

Do you have any allergies to medications or other substances (pets, 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.

General	□ None	□ Fever	□ Chills	□ Feeling Poorly
	□ Feeling Tired	□ Weight Gain	□ Weight Loss	
Eyes	□ None	□ Eye Pain	□ Vision Changes	□ Eyesight Problems
	□ Dry Eyes	□ Itchy Eyes		
Ear/Nose/Throat	□ None	□ Earache	□ Loss of hearing	□ Nose bleeds
	□ Sinus problems	□ Sore throat	□ Hoarseness	
Heart	□ None	□ Chest pain	□ Palpitations	□ Fast heart rate
	□ Slow heart rate	□ Leg swelling	□ Leg pain, discomfort, fatigue during walking	
Lungs/Breathing	□ None	□ Cough	□ Wheezing	□ Shortness of breath
	□ Trouble breathing with exertion		□ Trouble breathing when lying flat	
Gastrointestinal	□ None	□ Abdominal pain	□ Constipation	□ Diarrhea
	□ Heartburn	□ Nausea	□ Vomiting	□ Blood in stool
Bladder	□ None	□ Incontinence	□ Discolored urine	□ Painful urination
	□ Pelvic pain	□ Painful period	□ Vaginal Discharge	
Skin	□ None	□ Acne	□ Itching	□ Change in a mole
	□ Skin lesions	□ Skin wound	□ Breast pain	□ Breast lump
Neurological	□ None	□ Confused	□ Convulsions	□ Dizziness
	□ Limb weakness	□ Loss of memory	□ Headaches	□ Difficulty walking
Psychiatric	□ None	□ Anxiety	□ Depression	□ Change in personality
	□ Suicidal	□ Disturbed sleep	□ Emotional problems	
Endocrine	□ None	□ Weak muscles	□ Feeling weak	□ Deepening of voice
	□ Hair loss	□ Hot flashes		
Hem/Lymph	□ None	□ Easy bleeding	□ Easy bruising	□ Swollen glands

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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Additional Adult Orthopedic Information:

OFFICE USE ONLY		
Name: _____		
MRN#: _____		Age: _____
Height: _____	Weight: _____	BP: _____
Pulse: _____	BMI: _____	

Primary Care Provider (PCP): _____

Referring Provider: _____

Additional Provider(s) you would like consult letter sent to:

Provider Name: _____ Phone: _____

Address: _____

Provider Name: _____ Phone: _____

Address: _____

Reason for today's visit: _____

_____

Location of pain (include side): _____ Right or left hand dominant? _____

How long has it been present? _____ Is pain: Dull? Sharp? Tingling? Other: _____

When does pain occur? (Circle) At rest? With activity? At night? Other: _____

Pain severity: scale of 1 (very little pain) to 10 (excruciating/can't function). Circle number below:

1 2 3 4 5 6 7 8 9 10

What reduces the pain? (Circle) Medicine Ice Heat Rest Elevation

Has the problem improved or worsened? _____

Are there any other symptoms associated with the current problem? _____

_____

How did it occur? _____

Result of injury? □Y □N Worker's Comp? □Y □N No Fault/Car Accident? □Y □N

Does your home have: (Circle all that apply) Apartment 1 story 2 story 3+ Story Entrance steps Elevator

Do you exercise regularly? □Y □N Involved in organized sports? □Y □N