STATE EMPLOYEES' INSURANCE BOARD HEALTHCARE CENTER New Patient Intake Form



Last Name:	First Name:	:			Middle Initial:	Date of Birth:
Primary Insurance Contract Number:			Primary I	nsura	nce Group Num	ber:
Secondary Insurance Contract Number:	Seco		Secondar	ary Insurance Group Number:		
Address (Street, City, State, Zip):				Prefe Cont [act Phone Numl erred act CELL: WORK: HOME:	per:
Email Address:	Pharmac	y:			Primary Phys	ician:
Specialist Physician Name And Specialty:	e And Specialty: Spec		Specialist Physician Name And Specialty:			
Emergency Contact:		_	ne Numbe ition:	r:		

Please list anyone that you give permission for us to discuss your personal health information with:

Name

Relationship to Patient

Past Medical History:	Please put a check (\checkmark) next to all items that apply to you:
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Allergic Rhinitis (Hayfever)	Gastroparesis		Prostate Enlargement (BPH)
Anemia	Glaucoma		Psoriasis
Anxiety / Nerves / Nervous Breakdown	Gout		Psoriatic Arthritis
Asthma	Headaches (Type:)		Sexual dysfunction
Arthritis (Type:)	Heart attack (MI)		Stroke
Bladder / Kidney infections	Heart disease (CAD)		Sleep Apnea
Cancer (Type:)	Heart Failure (CHF)		Thyroid disorder
Cataracts	Heart valve replacement		Ulcer (PUD)
Chest Pain (angina)	Heartburn		Urinary frequency
Chronic Obstructive Lung Disease (COPD)	High blood Pressure (HTN)		Urinary hesitancy
Chronic Pain (Type:)	High cholesterol		
Constipation	High triglycerides	Oth	ner:
Depression	Incontinence		
Diabetes / High Blood Sugar	Insomnia (Difficulty Sleeping)	Oth	ier:
Diarrhea	Irritable Bowel (IBS)		
Dizziness	Menopause	Oth	ner:
Eczema	Osteoporosis		
Foot Infections / Leg Sores	Pneumonia		

Medication Allergies:

Type of Reaction:

Other Allergies: _____

Additional Information Concerning Your Health History:

Past Surgical History / Hospitalizations:

Have you ever needed to go to the emergency room for care or been admitted to the hospital? Have you ever had outpatient or inpatient surgery? If so, how old were you when this happened? What was the reason for this care?

Year at Time of Care	Reason for ED Visit of Hospitalization – OR- Type of Surgery

Family History (check all that apply):

	MOM	DAD	<u>SIBLING</u>
Diabetes			
□ High Blood Pressure			
High Cholesterol			
Heart Disease			
Cancer			

Social History:

- **Tobacco:** Do you currently use any type of tobacco (cigars, cigarettes, chewing tobacco, snuff, etc.)? _____
- Have you ever used any tobacco products? ______
- If yes, what type of tobacco?______
 At what age did you start? ______
 How long have you or did you use these products? ______
 How much did you or do you use per day on average?______

Alcohol: Do you consume alcoholic beverages?______

- If yes, what type of alcohol do you drink?______
- How often do you drink?_____
- How much do you typically drink each time?_____
 Do you have a history of alcohol abuse?______
- Drugs: Do you use recreational drugs (marijuana, cocaine, etc.)? ______
- If so, what type?______
- Caffeine: Do you ingest caffeine (colas, tea, coffee, chocolate, etc.)?_____ How many servings of caffeinated foods or beverages do you ingest every day on average?______
- **Diet:** Do you follow any special or restrictive diets (low-salt, low-fat, low-carb, diabetic, high protein, etc.)?_____
- Exercise: Do exercise regularly?____
- If so, describe your exercise program (types of activities, frequency, length, etc.)

Do you take any prescription or over the counter medications? If so, please provide the following information:

Medication Name	Dose (milligrams, units, etc.)	When do you take it? (time of day)	When did you start taking this medication?	What is this medication for?

To help us verify your immunization record, please respond to the following:

VACCINATIONS	YES	NO
I am 50 years old or older and have had a shingles		
vaccination		
I have received a Tetanus/diphtheria (TD or TDaP)		
vaccination in the past 10 years		
I am 65 years old or older and have received a pneumonia		
vaccination		
I am less than 65 years old and have lung (including COPD		
or asthma), heart (not including high blood pressure), or		
liver disease; diabetes; smoke cigarettes; or have a history		
of alcoholism and have had a pneumonia vaccine		
I am between the ages of 12 and 26, and have received an		
HPV vaccine series (Gardasil® or Cervarix®)		
I am at high risk for contracting meningitis (eg. college		
student living in dormitories, U.S. military recruit, traveling		
to parts of the world where meningitis is common, exposure		
to meningitis during an outbreak, or working in a laboratory		
with routine exposure to meningococcal bacteria) and have		
received a meningitis vaccination.		
I receive a flu vaccination every year		

If you are interested in receiving any of our available immunizations, please speak to someone at the front desk.

If you have any questions regarding any of our available immunizations, please consult with a member of our clinical team.

AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR SERVICE. I hereby consent to the services provided by the SEIB Wellness Center. I understand that these services may include limited physical assessment, lab testing and non-invasive testing along with cognitive services.

____ (initial)

PRIVACY POLICY. I acknowledge having received the "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke my consent for release of my health care information in writing, except to the extent the SEIB Wellness Center has already made disclosures with my prior consent. _____ (initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my personal health information for the purposes of diagnosis or treatment, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the SEIB Wellness Center. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the SEIB Wellness Center may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____ (initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT

I authorize payment to be made directly to the SEIB Wellness Center for insurance benefits payable to me. I understand that I am financially responsible for any covered or non-covered services, as defined by my insurer.

_____ (initial)

Patient or Authorized Person Signature	Relationship	Date

CONTACT INFORMATION FORM

Patient Request for

Confidential Communication of Protected Health Information

I,_____ (patient name), do hereby request that my pharmacist provider communicate with me in a confidential manner by using the following methods of communication and contact information when wishing to reach me.

 If contacting me in writing: Street Address/P.O. Box:

City, State and Zip Code:

- □ If contacting me by telephone:
 - Yes / No Talk to me only
 - > Yes / No May leave message with person answering phone
 - Yes / No May leave message on answering machine
 - Telephone Number: Work / Home
- If contacting me by telephone, and I am not available please call: Telephone Number: Work / Home
- If contacting me electronically: E-mail address:

Please indicate which contact method you prefer Understanding and Acknowledgement

- 1. I acknowledge that by requesting confidential communications I may prevent the use and disclosure of my PHI to family members, friends, caregivers, and others that might be for my benefit.
- 2. I understand that I am responsible if the contact information provided above is incorrect, or if it is later changed and I fail to report the change.

Signature of Person Submitting Request

Date