New Patient Intake Form

Last Name:	First Name:	Middle Initial:	Date of Birth:

Insurance Contract Number:	Insurance Group Number:

Address (Street, City, State, Zip):	Contact Phone Number:

Email Address:	Pharmacy:	Primary Physician:

Specialist Physician Name And Specialty:	Specialist Physician Name And Specialty:

Past Medical History: *Please put a check (✓) next to all items that apply to you:*

☐ 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	☐ Weakness/ Tired
☐ Constipation	☐ High triglycerides	Other: ______________________
☐ Depression	☐ Incontinence	
☐ Diabetes / High Blood Sugar	☐ Insomnia (Difficulty Sleeping)	Other: ______________________
☐ Diarrhea	☐ Irritable Bowel (IBS)	
☐ Dizziness	☐ Menopause	Other: ______________________

☐ Eczema	☐ Osteoporosis	
☐ Foot Infections / Leg Sores	☐ Pneumonia	

Allergies: ____

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____

Additional Information Concerning Your Health History:______________________________

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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?

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

Family History (check all that apply):

- ❑ Obesity
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Disease
- ❑ Cancer

Social History:

- **Tobacco:** Do you currently or have you ever used any type of tobacco (cigars, cigarettes, chewing tobacco, snuff, etc.)?
  ❑ Current Smoker ❑ Former Smoker ❑ Never Smoked
- If you are a current smoker, 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.) ____ ____

TigerMeds Program for AU Employees and beneficiaries:

- Do you use the **AU Employee Pharmacy**?________
- If so, have you had your **TigerMeds Checkup** for this year?_________
- If no, would you like to **schedule** a TigerMeds Checkup?___________

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?**

Auburn University Pharmaceutical Care Center (AUPCC)

Please answer the following questions so we can determine which payment fee tier you will fall under for payment of services you will be receiving from the Auburn University Pharmaceutical Care Center.

Please select one of the following:

- ❑ I am an AU Employee
- ❑ I am the dependent of an AU Employee and am covered by the AU insurance plan
- ❑ I am an AU Student
- ❑ I am an AU retiree
- ❑ I have been referred to the AUPCC by my physician (a written or phone referral is required)
- ❑ None of the above

Please select one of the following:

- ❑ My income is less than $40,799
- ❑ My income is more than $40,800

____

Patient signature/Date

AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR SERVICE. I hereby consent to the services provided by the Auburn University Pharmaceutical Care Center (AUPCC). 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 AUPCC's, "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 explain 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 AUPCC 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 AUPCC. 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 AUPCC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.__________(initial)

_________________________________ ______________________ ___________

Patient of 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