New Patient or Re-establish Request Intake Form

Intake Date: ___/___/___ Form Completed By: _____

Name: _____

Date of Birth: _____/____/___ □ Male □ Female □Other

How did you hear about us? _____

Address: _____

City: _____State: _____ Zip: _____

Provider Requested:_____

OR No Preference Routed to: _____

Will you accept this NP? YES or NO

Date_____ Initials_____

Primary Phone #: (_____) _____ *cell / home /*OK to Leave Detailed Message? □ Yes □ No

Secondary Phone #: (____) _____*cell / home /*OK to Leave Detailed Message? □ Yes □ No

Email Address: _____

Emergency Contact Name:_____Relationship:_____

Phone_____

Currently Employed? □ *Yes* □ *No* □ *Retired*

Guardian Name**(if applicable)*_____ Relationship: _____

Primary Insurance		Secondary Insurance	
Contract ID		Contract ID	
Group #		Group #	

For WFPC Staff to Review with potential patient

**Please know that our office provides and coordinates an individual health plan to meet important health goals for our patients. To do that our providers need to see patients for regular preventive appointments. Multiple years of inactivity may cause a patient's status to become inactive.*

Current and/or Previous Treatment Provider Information

Are you currently seeing another physician and/or specialist(s)? □ *Yes □ No

*If yes, which **PCP** are you seeing? _____Location: _____

What was the date of your last Physical? ____/____/___

*If yes, which **Specialist** are you seeing?_____Location: _____

Have you ever been discharged from another medical practice? □ *Yes □ No

*If yes, what is the name of the practice and why were you discharged?

_____

<<<<Page 1 Over >>>>>

New Patient or Re-establish Request Intake Form

Required Basic Health and Prescription Information

WFPC Staff>>>>Review this explanation of health & Rx intake with potential patients

**To comply with new state regulations - part of our new patient screening process we must ask potential new patients questions about medications and health conditions to ensure we are able to provide you with the healthcare you are expecting and may require.*

**Please be aware - there could be situations when it will be determined our practice will not be able to continue certain controlled medications or courses of treatment you may be or have been receiving elsewhere.*

**The next several questions are important and are required in order to review your request to become a new patient at West Front Primary Care, LLC with our providers. If it is determined later that medications are not disclosed during the intake process it may result in discharge from the practice. Thank you for being candid.*

Are you currently taking any controlled substances? □ *Yes □ No

(i.e. Ultram, Norco, Percocet, Vicodin, Ritalin, Adderall, Vyvance or Benzodiazepines, such as Xanax, Klonopin, Ativan, Valum, etc)

*If yes, which controlled substance(s):_____

_____

Have you been treated for or ever been diagnosed with chronic pain using regularly scheduled controlled substances? *(i.e.Ultram, Norco, Percocet, Vicodin, etc)* □ Yes □ No

What medications are you currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What conditions are you currently being treated for or have been diagnosed with?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

<<<<<<Page 2>>>>>

Pediatric Medical History Questionnaire

Appointment Date/Time _____

Patient's Name _____ Birth Date _____ Sex _____

Previous Physician _____ Pharmacy _____

Are you taking any medications, pills, or supplements? ☐ Yes ☐ No (Please list) _____

_____

_____

Are you allergic to any medication or latex? ☐ Yes ☐ No (Please list) _____

_____

Please indicate if you have had any of the following

☐ Acne	☐ Concussion	☐ Heart Murmur	☐ Any other (Please list)
☐ ADD/ADHD	☐ Congenital heart disease	☐ Otitis media, recurrent	_____
☐ Allergic rhinitis	☐ Constipation	☐ Pneumonia	_____
☐ Anemia	☐ Diabetes (type) _____	☐ Prematurity	_____
☐ Asthma	☐ Eczema	☐ Pyelonephritis	_____
☐ Birth trauma	☐ Fracture	☐ Seizure disorder	_____
☐ Bleeding disorder	☐ GERD	☐ Urinary tract infection	_____
☐ Bronchitis/bronchiolitis	☐ Headache/Migraine headache	☐ Vesicoureteral reflux	_____
☐ Bleeding Problems	☐ Glaucoma/eye disorder	☐ Stroke	_____
☐ Cancer	☐ Headache/Migraines	☐ Thyroid Disease	_____

Have you had any surgeries? ☐ Yes ☐ No (please list-include year, physician and what was done)

_____

_____

Family History (Please list any conditions that run in your biological family-even if they are deceased or alive and well)

	Father/Mother/Child Grandfather/Grandmother Sister/Brother		Father/Mother/Child Grandfather/Grandmother Sister/Brother
	Father/Mother/Child Grandfather/Grandmother Sister/Brother		Father/Mother/Child Grandfather/Grandmother Sister/Brother