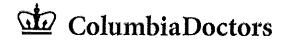


New Patient Intake Form

Patient Information											
Last Name:	First Name:			DOB:							
Preferred Phone:	Email:		·	Gender:							
Emergency Contact:		Relati	onshij	D:							
Emergency Contact Phone:		Patient Marital Status:									
Occupation: Primary Care Provider (PCP): PCP Address: Preferred Pharmacy: Preferred Pharmacy Address:			Employer: PCP Phone: Pharm Phone:								
								nation is encouraged by f of care provided to all pa	ederal h		agencies. This information is used to
								ecline Response		σЕ	Black or African American
☐ Hispanic or Latino ☐ A	merican-Indian or Alaska	Native		Native Hawaiian or Pacific Islander							
□ Not Hispanic or Latino □ A	sian			Vhite □ Other							
Preferred Language:											
Patient Signature:			_ 🗆 🗜	Pater							
	· · · · · · · · · · · · · · · · · · ·			Date:							
requested or to racilitate payment	full payment for all charg be paid directly to Columb ors to release pertinent m tof a claim.	es not co piaDocto nedical ir	overed ors for oform	d by my insurance company. I services rendered. I authorize ation to my insurance company wher							
Patient or Guarantor Name (Print)											
Patient or Guarantor Signature:				Date:							
Patient Name (Print):	with a copy of the Colum	nbiaDoct	ors N	otice of Privacy Practices (NOPP).							
				Date:							
f completed by a patient's personal	representative, please pr	int and s	ign be	low							
Representative (Print):				_ Relationship:							
representative Signature:				Date:							
nyColumbiaDoctors Patient Port	ai Sign Up		ı								
Access your personal records secur Send me an invitation to join my	ely, 24/7, on a computer,	smartpl	none,	or iPad. See brochure for details.							
Look for an email invite from no	roply@follows.sharles		11 1 .1	B 1							
Look for an email invite from no	iehiy@ronowinyneaith.c	vig and c	IICK tr	ne Registration link.							

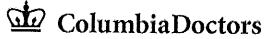


Reason for today's vi	sit:			**************************************			
General Medical Que Have you EVER had a							
Asthma/Breathing Pr	oblems a Y	oN H	eart Diseas	se/Disorder	🗆	Y DN	
Arthritis							
Please list any surgeries you have had and the appr Procedure		Date			Complications		
	ajor conditions/illnesses that y				7		
Relative Mother	Condition and description		Living?	If deceased, at who	at age?		
Father				OY ON			
Sibling						<u> </u>	
Other:				OY ON			
	ke? □Y □N If no, previou acco products? □Y □N						
	gies to medications or other so gies and reactions (including ra				ylaxis).		



Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name: Address:					
Address.			-		
Specialty:		Fax Number:			
Doctor's Name:					
110010001					
Phone Number:	Fax Number:				
Specialty:					
Doctor's Name:					
. 144. 455.					
THORE NUMBER:		Fax Number:			
Specialty:					
Doctor's Name:					
Address:	E				
Phone Number:	Fax Number:				
Specialty:					
/ ladi C55.					
rhone Normber:	Fax Number:				
Specialty:					
Please list ALL of your current med		over the counter medications, supplen	nents, and herbs:		
Medication Name	Dose	Medication Name	Dose		
,					
Provider Signature:		Date:			
. To that originators,		Date:			



Review of Systems

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

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

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