New Patient Intake Form

Name (First):_____(M.I):____ (Last):_____

Address:_____ (Apt, Lot, etc.):_____

City:_____ State:_____ Zip:_____

Home # :_____ Cell Phone #:_____ Work Phone #_____

Best Method to contact (circle one) Home, Cell or Work Ok to leave a voicemail? Yes No

EMAIL: _____

Marital Status (circle one): Single Married Divorced Separated Widowed

Date of Birth: _____ SSN: _____

In Case of Emergency (Name): _____ (Phone): _____

Pharmacy Name: _____ (Phone): _____

Do you have any Allergies? _____

Do you have a preferred lab? _____

PLEASE GIVE ALL INSURANCE INFORMATION INCLUDING YOUR CARDS TO THE FRONT DESK AT CHECK-IN

CURRENT MEDICATION LIST

Medication Name	Dose	Frequency

FAMILY HISTORY

Relationship	Medical Issues	Age	Age & Cause of Death
Father			
Mother			
Brothers			
Sisters			

SURGICAL & HOSPTAIL HISTORY

YEAR	HOSPITAL	REASON FOR STAY

MEDICAL HISTORY

YEAR DIAGNOSED	MEDICAL DIAGNOSIS	YEAR DIAGNOSED	MEDICAL DIAGNOSIS

SOCIAL HISTORY

Do you live alone? Yes No **Do You have any children?** Yes No **If so, how many?** _____

Do you exercise? Yes No **Do you drink Caffeine?** Yes No **If yes what type and how much?** _____

Do you drink Alcohol? Yes No **If yes how often?** _____

Do you smoke? Yes No **If yes what type and how often?** _____

Are you Employed? _____ **If yes where and what is your job description?** _____

What are you hoping to get out of your first visit?

_____
_____
_____
_____
_____
_____

How did you find us? _____

Notice of Privacy Practices and PCMH Information

I acknowledge that I have read and/or received a copy of West Bloomfield Internal Medicine's Privacy Practices and Patient Center Home Health care form.

Patient Signature: _____

Patient Print Name: _____

Date: _____