New Patient Intake Form

Yadkin Valley Gastroenterology

Name: _____ Spouse: _____

Birth Date: _____ Social Security No: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Referred By: _____

Insurance (BRING CARD): _____

Allergies: *(check all that apply)*

☐Codeine ☐Bee Sting ☐Sulfa ☐Penicillin ☐Other: _____

Current Medications:

Name	Dose (mg)	How many times per day?

Primary Care Physician Full Name: _____

Address: _____

Phone: _____ Fax: _____

continued

What other doctors are you seeing?

Doctor	Why are you seeing him/her?	Location

Have you ever been hospitalized or had surgical procedures? ☐Yes ☐No

When	Where	Reason

Have you ever had a blood transfusion? ☐Yes ☐No

When: _____ Reason: _____

Please check any of these products that you use:

Tobacco: ☐Cigarettes _____ per day ☐Snuff ☐Chewing Tobacco

Alcohol: ☐Beer ☐Wine ☐Spirits ☐Other _____

Caffeine: ☐Coffee ___ cups per day ☐Soft Drinks ___ cans per day ☐Tea ___ glasses per day

continued

Please circle any illnesses or health problems you may have or have had:

Heart Attack	Seizure/Epilepsy	Diabetes Mellitus
Stomach Ulcers	Hiatal Hernia	Stroke
Colon Cancer	Breast Cancer	Lung Cancer
Asthma	Emphysema	Tuberculosis
High Blood Pressure	Elevated Cholesterol	Arthritis
COPD	Anemia	Migraines / Severe Headache
Glaucoma	Thyroid Disease	Hepatitis
Kidney Disease	Cirrhosis	Cold / Productive Cough

Mother: ☐Living ☐Deceased Cause of death _____

Father: ☐Living ☐Deceased Cause of death _____

Please circle any family illnesses. List the relatives using the key at the right side.

Heart Surgery:
Seizure/Epilepsy:
Stroke:
Breast Cancer:
Colon Cancer:
High Blood Pressure:
Elevated Cholesterol:
Stomach Ulcers:
Arthritis:
Tuberculosis:
Heart Attack:
Diabetes:
Lung Disease (emphysema/asthma):
Lung Cancer:
Other:

M = Mother
F = Father
B = Brother
S = Sister
A = Aunt
U = Uncle
MGM = Maternal Grandmother
PGM = Paternal Grandmother
MGF = Maternal Grandfather
PGF = Paternal Grandfather

continued

Emergency Contact Information

Name of person ***not living with you***_____

Relationship_____

Address:_____

Home Phone:_____ Work Phone:_____

Name of person ***not living with you***_____

Relationship_____

Address:_____

Home Phone:_____ Work Phone:_____

Assignment of Benefits:

I hereby assign payment directly to Yadkin Valley Gastroenterology of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered.

Release of Information:

I hereby authorize Yadkin Valley Gastroenterology to release such medical information as may be required by any insurance company concerned with payment of benefits for me. I further authorize Yadkin Valley Gastroenterology to release medical information to any facility or physician to whom I am referred. These authorizations shall remain in effect until I provide written notice revoking them.

Authorized Recipient of Information:

I hereby authorize Yadkin Valley Gastroenterology to discuss my health condition with

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
Signature of patient or responsible party Date

Privacy Notice:

I acknowledge that I have received the Yadkin Valley Gastroenterology Privacy Notice as required by the Health Insurance Portability and Accountability Act (HIPPA).

_____ _____
Signature of patient or responsible party Date