



Please return this completed form prior to your visit with a provider

New Patient Update

Section 1: Patient Information

Last Name	First Name	Middle Initial
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Social Security Number	Birth Date
Mailing Address	City, State	Zip
Home Phone	Cell Phone	Message Phone
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other: _____	Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Housing <input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnicity / Race <input type="checkbox"/> Alaskan Native\Native American <input type="checkbox"/> Non Native <input type="checkbox"/> Hispanic		
Languages	Interpreter Required	Chaperone
Employment Status <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed		
Employer Name	Employer Address	Employer Phone
Monthly Income	Household Income	Total People in Household
Emergency Contact Name	Emergency Contact Number	Emergency Contact Relationship

Section 2: Guarantor/Legal Guardian

Relationship to Patient		Gender
Last Name	First Name	Birthdate
Mailing Address	City State	Zip

Section 3: Primary and Secondary Insurance

Insurance Company Name	Group Number	Subscriber ID Number
Subscribers Full Name	Employers Name	Co-Payment
Insurance Company Name	Group Number	Subscriber ID Number
Subscribers Full Name	Employers Name	Co-Payment

Section 4: Acknowledgment

Please Initial

CONSENT TO CARE

I consent to the plan of care proposed by the providers in the Primary Care Clinic at CRNA. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my health care and will make my wishes known. I understand that CRNA participates in the training of physicians and other healthcare providers and will be told when trainees take part in my care.

NOTIFICATION OF RELEASE FOR PAYMENT

I understand that CRNA will disclose any diagnoses and pertinent information to the extent required at assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical, dental and behavioral health.

FINANCIAL AGREEMENT

I understand that any applicable co-payments, discounts and prompt pay charges are due at time of service, including fees for services not covered by the I H S, if I am an eligible beneficiary. I assign payment from my insurance directly to CRNA. I understand I am financially responsible to CRNA for charges not paid by my insurance and that payment for those charges is due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills for laboratory, radiology, and other specialized services.

PAYMENT AGREEMENT

I understand that CRNA, under certain circumstances, may offer me the opportunity to repay my portion of services provided under a payment agreement. I understand that this is a legally binding agreement and I am responsible to meet the terms of the agreement.

NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of CRNA's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of this notice at any time.

I have read the above and initialed my consent and financial responsibility for services at CRNA. If I have a question about my visits or any financial liability, I will contact CRNA registration prior to my appointment.

Date: _____

Patient Signature _____

Guardian Signature _____

OFFICE USE ONLY

Staff Initials: _____

Patient MRN #: _____

Date Entered In CERNER: _____

- Patient refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prohibited obtaining acknowledgment
- Other: _____



This information truly helps us to provide you with comprehensive care.

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Health Summary

As a new patient and to help us understand any health issues that you may have, please fill out the information below to the best of your ability. We ask that you complete this form on annual basis so that we can provide you with exceptional care and monitor any changes in your health. All information is strictly confidential.

Patient Name: _____ **Date of Birth:** _____ **Intake Date:** _____

Chief Complaint: _____

Allergies: _____ **Last Physical:** _____

DENTAL SECTION	Last Dental Exam: _____
Have you had problems with prior dental treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you in pain now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever taken Bisphosphonates:	<input type="checkbox"/> Fosamax <input type="checkbox"/> Actonel <input type="checkbox"/> Boniva <input type="checkbox"/> Skelid <input type="checkbox"/> Didronel <input type="checkbox"/> Reclast/Zometa

Patient Medical History *Please check all that apply. Leave blank if unsure.*

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Herpes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> IBS/Diverticulitis | <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Infectious Mono | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Aids/HIV |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hernia | <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Blood/Plasma Transfusion | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> STD | | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Bruising | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates: _____

Medications: (Include inhalers, herbs, supplements and over-the-counter items): _____

Patient Social History:

Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Alcohol Use <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Regularly Amount Per Day: _____	Smoking <input type="checkbox"/> Never <input type="checkbox"/> Currently Amount Per Day: _____ <input type="checkbox"/> Previously, but quit on date: _____	Smokeless Tobacco <input type="checkbox"/> Never <input type="checkbox"/> Currently Amount Per Day: _____ <input type="checkbox"/> Previously, but quit on date: _____
Caffeine Use <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Regularly Amount Per Day: _____	Drug Use: Types _____ <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Regularly Amount Per Day: _____	Exercise Type: _____ <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Regularly Amount Per Day: _____	Traumatic Events:

Family Medical History: *Please check if a family member has had any of the following and check the relationship to you;*

Diabetes	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
Cancer	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
Heart Disease	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
Hypertension	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
Death Before Age 50	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child

As a new patient and to help us understand any health issues that you may have, please fill out the information below to the best of your ability. We ask that you complete this form on annual basis so that we can provide you with exceptional care and monitor any changes in your health. All information is strictly confidential.

General Health (Past Year)

- Good
- Poor
- Recent Weight Change: _____ lbs.
- Fatigue/Poor Energy
- Sleeping Problems/Snoring

Ear/Nose/Mouth/Throat

- Hearing Loss
- Ear Pain
- Ear Infections
- Sinus Infections/Problems
- Nose Bleeds
- Mouth Sores
- Bleeding Gums
- Bad Breath/Bad Taste
- Sore Throat
- Swollen Gland in Neck
- Voice Change

Cardiovascular

- Last Cholesterol Screen Date: _____
- Heart Trouble/Attack
- Chest Pain/ Angina
- Heart Medications
- Heart Murmur
- High Blood Pressure
- Shortness of Breath at Rest
- Pain in Legs
- Swelling in Ankles
- Varicose Veins
- Cold Extremities

Musculoskeletal/Pain

- Muscles Aches/Cramping
- Joint Pain
- Joint Swelling
- Low Back Pain
- Neck Pain
- Joint Stiffness
- Difficulty Walking Standing
- Osteoporosis
- History of Injuries and Accidents
- Date: _____
- Details: _____
- Date: _____
- Details: _____

Urinary Tract

- Frequent Urination
- Nighttime Urination
- Urgency/Burning/Painful Urination
- Blood In Urine
- Change in Urine Stream
- Incontinence or Dribbling
- Kidney Stones
- Sexual Difficulty
- Male: Testicle Pain
- Male: Last Prostate Check: _____

Skin/Breast/Immune System

- Rash/Itching/Hives
- Dry Skin
- Eczema
- Psoriasis
- New or Changing Moles
- Breast pain
- Breast Discharge
- Breast Lump
- Allergies:
 - Food Seasonal
 - Environmental: _____
 - Other: _____
- Immune Deficiency/Compromise

Gastrointestinal

- Colon Cancer Screen Date: _____
- Appetite:
 - Good Poor Excessive
- Recent Change in Appetite
- Nausea or Vomiting
- Heartburn/Reflux
- Abdominal Pain
- Bloating
- Bowel Movements: # Per Day _____
 - Easy Difficult
- Skip Days of Moving Bowels
- Change in Bowel Habits
- Rectal Bleeding or Blood in Stool

Eyes

- Eye Disease or Injury
- Wear Glasses/Contacts
- Blurred Vision
- Double Vision

Neurological/Psychological

- Headaches
 - Daily Weekly
- Migraines
- Sinus Headaches
- Dizziness
- Light Headed
- Convulsions of Seizures
- Tremors
- Paralysis
- Numbness or Tingling
- Depression
- Anxiety/Nervousness
- Memory Loss/Confusion
- Abuse Survivor
- Trouble Sleeping

Female

- Last Period Start Date: _____
- Periods Are:
 - Regular Irregular
- Monthly Cycle: # of Days _____
- PMS:
 - Irritability
 - Emotional
 - Breast Tenderness/Swelling
 - Other: _____
- Vaginal Discharge or Itching
- # of Pregnancies: _____
- # of Live Births: _____
- Menopause Symptoms:
 - Hot Flashes
 - Night Sweats
 - Vaginal Dryness
 - Other: _____
- Date of Last Mammogram: _____
 - Normal Abnormal
- Date of Last PAP Smear:
 - Normal Abnormal

Respiratory

- Cough
- Shortness of Breath
- Wheezing/Asthma
- Coughing Up Blood