New Patient Intake Form
White River Family Practice

Please Print Clearly

Patient Name: ______________________ Date of Birth:______ Last Four SSN: ______
(last name, first name, middle initial) Birth Sex: ☐Male ☐Female
Mailing Address:____
(Street) (City/State/Zip)
Physical Address (if different from mailing):______________________________
Home Phone:______________________ Cell Phone:______________________
Marital Status: ☐Married ☐Single ☐Divorced ☐Widow
Race: ☐White ☐African American ☐American Indian ☐Asian ☐Other
Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino
Primary Care Provider:____
Primary Language:______________________ E-Mail address:______________________
Employer:______________________ Occupation:______________________
Work Phone:______________________
Preferred Pharmacy:____
Preferred Name (what do you prefer we call you, if different than above):______________________
Alternate Contact : ______________ Relationship:__________ Phone:______________

FIRST INSURANCE INFORMATION:

Plan Name:______________________ Policy Number:______________________
Address:______________________ Group Number:______________________
Policy Holder:______________________ Policy Holder's Date of Birth:______________________
Policy Holder's Relation to Patient:______________ Effective Date:______________________

SECOND INSURANCE INFORMATION:

Plan Name:______________________ Policy Number:______________________
Address:______________________ Group Number:______________________
Policy Holder:______________________ Policy Holder's Date of Birth:______________________
Policy Holder's Relation to Patient:______________ Effective Date:______________________

PARENT/GUARDIAN or PERSON RESPONSIBLE FOR BILL (Complete only if different from patient):

Name:______________________ Social Security Number:______________________
Address:____
Home Phone:______________________ Relation to Patient:______________________

PRIOR HEALTH CARE/ADVANCE DIRECTIVES:

Last Primary Healthcare Provider – Name & Location:______________________
Do you have a **Living Will**: ☐Yes ☐No
Do you have a **Durable Power of Attorney** for Health Care: ☐Yes ☐No
If yes, who:______________________ Relationship:______________________
Phone number:______________________

New Patient Intake Form
Primary Care

Name:

MR#:

DOB:

PAST MEDICAL HISTORY (check only if applies):

- ☐ ADD or ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Benign Breast Disease
- ☐ Bipolar
- ☐ Chlamydia (sexually transmitted infection)
- ☐ Chronic Hepatitis or Liver Disease
- ☐ Chronic Kidney Disease
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Diverticulitis
- ☐ DVT (blood clot in leg)
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ GERD or reflux disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Stones
- ☐ Migraine Headaches
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Psoriasis
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Recurrent Urinary Tract Infections
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Street Drug Use
- ☐ Stroke
- ☐ Thyroid Disease

- ☐ Other disease not listed above: ____________________
- ☐ Other disease not listed above: ____________________
- ☐ Cancer – Type: ____________________
- ☐ Cancer – Type: ____________________
- ☐ Hospitalization – Reason/Year: ____________________
- ☐ Hospitalization – Reason/Year: ____________________
- ☐ Hospitalization – Reason/Year: ____________________
- ☐ Hospitalization – Reason/Year: ____________________
- ☐ Surgery – Type/Year: ____________________
- ☐ Surgery – Type/Year: ____________________
- ☐ Surgery – Type/Year: ____________________
- ☐ Surgery – Type/Year: ____________________

Women only: Age at first period:__________ Age at menopause:__________
# of pregnancies:_____ # of live children born:_____ # of miscarriages or abortions:______

MEDICATIONS (Including eye drops/creams/supplements/over-the-counter medications)**:**
(list all with dose and frequency) Please attach a separate sheet if you need more room: ☐ see attached

____
____
____

ALLERGIES (Including medications, foods, other environmental triggers such as Latex)**:**
(give reaction details such as hives, swelling, diarrhea, etc)

____
____
____

New Patient Intake Form
Primary Care

Name:

MR#:

DOB:

FAMILY HISTORY (relative – for example mother, father, sibling, etc.):

- ☐ Heart Attack – Relative/Age:__________
- ☐ Heart Disease – Type/Relative:__________
- ☐ High Cholesterol – Relative/Age:__________
- ☐ Diabetes – Relative:__________
- ☐ Sudden Unexplained Death – Relative/Age:__________
- ☐ Colon Cancer – Relative/Age:__________
- ☐ Breast Cancer – Relative/Age:__________
- ☐ Cancer – Type/Relative:__________
- ☐ Cancer – Type/Relative:__________
- ☐ Other Illnesses - Relative:__________
- ☐ Other Illnesses - Relative:__________
- ☐ Other Illnesses - Relative:__________
- ☐ Other Illnesses - Relative:__________

SOCIAL HISTORY:

Who do you live with? __________

Do you feel safe at home? ☐ Yes ☐ No Have you ever felt threatened in your home? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes – how much per day:_____ for how long:_____

Did you smoke in the past? ☐ Yes ☐ No If yes – how much:_____ for how long:_____

Do others at home smoke? ☐ Yes ☐ No If yes – who:_____

Do you chew tobacco? ☐ Yes ☐ No If yes – how much:_____ for how long:_____

Do you drink alcohol? ☐ Yes ☐ No If yes – how many drinks per week:_____

Do you use marijuana? ☐ Yes ☐ No

Do you use other street drugs ☐ Yes ☐ No If yes – what:_____

Sexual partners (now or in past): ☐ Male ☐ Female ☐ Both ☐ None

PREVENTATIVE HEALTH CARE INFORMATION (approximately**):**

Last Physical Exam:	Date: _____		
Last blood test for Cholesterol:	☐ Normal	☐ Abnormal	Date: _____
Last blood test for Sugar/Diabetes:	☐ Normal	☐ Abnormal	Date: _____
Last Pap smear:	☐ Normal	☐ Abnormal	Date: _____
Last Mammogram:	☐ Normal	☐ Abnormal	Date: _____
Last Colon Cancer screen:	☐ Normal	☐ Abnormal	Date: _____
Have you had a Pneumonia shot?	☐ Yes	☐ No	Date: _____
Have you had a Shingles shot?	☐ Yes	☐ No	Date: _____
Do you recall last Tetanus?	☐ Yes	☐ No	Date: _____

White River Family Practice, PC 331
Olcott Drive, Suite U3 White River
Jct., VT 05001
802-295-6132
802-295-1358 (Fax)
www.whiteriverfamilypractice.com

Name:______________________________ DOB:_____________ MRN:_____________

I authorize ____ to disclose my protected health information for the following purpose of **Continuity of Care** ___, transferring care _______.
Address: ____________________________________ Fax # ___________________________
I understand this information may include treatment for drug/alcohol abuse, mental illness, HIV status, or genetic testing records. I specifically authorize the release of this information (if applicable):

☐ Yes ☐ No Initials:______

Name of person(s) or entity to receive information:
White River Family Practice
331 Olcott Dr. Ste U3
White River Jct., VT 05001

If medical records are more than 25 pages please mail them to our office.

<u>INFORMATION TO BE DISCLOSED</u>:
Information Needed:

☐ Problem List	☐ Last year of progress notes	☐ Last year of labs/images
☐ Immunization	☐ Last physical	☐ Last pap
☐ Medication List	☐ Last 3 years of consults	☐ Most recent mammogram
	All ADHD Evaluations	Most recent colonoscopy

I understand that:

- I may refuse to sign this authorization and my healthcare and payment of my healthcare will not be effected based upon refusal to sign the authorization.
- I may revoke this authorization at any time by delivering to the health care provider/institution, authorized above, in a written note. I understand that the revocation will not apply to records that have been disclosed prior to receipt of the written revocation.
- If I authorize disclosure of my protected health information, and the recipient is not a covered entity, the recipient may further disclose this information and federal law will no longer protect it.
- I have the right to inspect of copy the information that I am consenting to release within the established policies of the provider or institution that I authorize to release my records.

This authorization will expire one year from the date this document is signed unless I otherwise specify an alternative date or event described here:____

_________________________________ _______________ __________
Signature of Patient/Personal Representative Phone Number Date

_________________________________ ______________________________
Printed Name of Personal Representative Legal Authority of Personal Representative

We will provide you a copy of this authorization at your request.