ColumbiaDoctors

Adult New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Gender: _____ Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____ PCP Phone: _____

Referring Provider: _____ Referring Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Preferred Language: ☐ Decline Response

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

☐ Received ☐ N/A (only if you received the notice from ColumbiaDoctors previously)

Information Disclosure and Consent

ColumbiaDoctors will provide you with the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

***Please refer to our website: columbiadoctors.org, for a list of insurances accepted by your provider.**

MRN _____

COLUMBIA NEUROLOGY SPECIALISTS: NEW PATIENT MEDICAL HISTORY

Please fill out ***completely*** and leave ***nothing*** blank. There are ***2 pages.***

Date _____ **Name** _____ **Age** _____ **DOB** _____ **Gender** _____ **Handedness** _____

Your Problem _____ **when did it start** _____

Referring Provider Name _____ Phone_____ Fax_____

Address_____ City_____ State_____ Zip_____

Past Medical/Surgical Problems (check ***yes*** or ***no*** to ***all*** questions)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	stroke/TIA	☐	☐	seizures/epilepsy	☐	☐	depression	☐	☐	anxiety
☐	☐	heart attack/angina	☐	☐	heart failure	☐	☐	anemia	☐	☐	bleeding disorder
☐	☐	heart arrhythmia	☐	☐	heart valve abnl	☐	☐	HIV/AIDS	☐	☐	cancer _____
☐	☐	high blood pressure	☐	☐	high cholesterol	Other, including operations _____					
☐	☐	asthma	☐	☐	COPD/emphys.	_____					
☐	☐	pulmonary embolus/DVT	☐	☐	stomach ulcer	_____					
☐	☐	stomach/intestinal bleeding	☐	☐	hepatitis	_____					
☐	☐	cirrhosis	☐	☐	kidney disease	_____					
☐	☐	kidney stones	☐	☐	enlarged prostate	_____					
☐	☐	diabetes mellitus	☐	☐	thyroid disorder	_____					

Do you have a pacemaker, defibrillator or implanted metal that would interfere with you getting a MRI? ☐ yes ☐ no ☐ not sure

If yes/not sure, please specify _____

Systems review/Are you ***currently*** experiencing (please check ***none*** or ***applicable symptoms*** in each row)

General	☐none	☐fever	☐chills	☐ malaise	☐fatigue	☐wt loss	☐wt gain
Eyes	☐none	☐eye pain	☐vision loss	☐eyes red	☐eye discharge	☐dry eyes	☐itchy eyes
ENT	☐none	☐earache	☐hearing loss	☐nosebleed	☐nasal discharge	☐sore throat	☐hoarseness
Cardiac	☐none	☐chest pain	☐palpitations	☐rapid heartbeat	☐slow heartbeat	☐leg swelling	
		☐leg pain when walking					
Resp	☐none	☐short of breath	☐short of breath on exertion		☐short of breath on lying		
		☐short of breath on awakening		☐wheezing	☐cough		
GI	☐none	☐abd pain	☐nausea/vomit	☐constipation	☐diarrhea	☐heartburn	☐bloody stool
GU	☐none	☐painful urination		☐incontinence	☐difficulties urinating		☐pelvic pain
		☐painful periods		☐ discharge	☐sexual dysfunction		
Muscle	☐none	☐joint pain	☐joint swelling	☐joint stiffness	☐limb pain	☐limb swelling	
Derm	☐none	☐rash	☐skin lesions	☐itching			
Neur	☐none	☐confusion	☐seizures	☐dizziness	☐limb weakness	☐ difficulty walking	
Psych	☐none	☐suicidal thoughts		☐anxiety	☐depression	☐hallucinations	
		☐personality change		☐sleep difficulties			
Endo	☐none	☐hot flushes	☐excessive urination		☐overall weakness	☐hot/cold intolerance	
Heme	☐none	☐easy bruising/bleeding		☐swollen glands			
Other	☐none	_____					

PLEASE COMPLETE PAGE 2

MRN._____

COLUMBIA NEUROLOGY SPECIALISTS: NEW PATIENT MEDICAL HISTORY: PAGE 2

Please fill out ***completely*** and leave ***nothing*** blank. There are ***2 pages***

Date _____ **Name** _____

Medications (including prescription over the counter, vitamins, supplements, herbs, etc.)
if ***none***, check here ☐

Name	Dose	Pills/day	Name	Dose	Pills/day

If applicable, please bring a list of prior medications used for your neurological condition

Medication Allergies (if ***none***, check here ☐) _____

List neurological diseases in your family and relation to you (if ***none***, check here ☐)

_____
_____
_____
_____
_____

Education ☐ less than high school grad ☐ high school grad ☐ college grad ☐ more than college grad
Working ☐ yes ☐ no Occupation _____
Marital Status ☐ single ☐ married ☐ separated/divorced ☐ widowed
With whom do you live _____
Do you currently smoke ☐ yes ☐ no. How much _____
If no, did you ever smoke ☐ yes ☐ no When did you stop _____
Do you currently drink alcohol ☐ yes ☐ no. How much _____
if no, did you ever drink alcohol ☐ yes ☐ no When did you stop _____
Do you currently use any recreational drugs ☐ yes ☐ no Which one(s) _____
Do you currently exercise ☐ yes ☐ no How much _____
If a woman, are you pregnant ☐ yes ☐ no

Patient signature _____ **Provider Signature** _____ **Date** _____