ELEVATED PRIMARY CARE

New Patient Questionnaire

(Please print clearly and fill out entirely)

Welcome to Elevated Primary Care

Full Name ______________________________ SSN# ______________

Former/Maiden Name ______________________ Preferred Name ______________

Date of Birth ______________ Age ________ Gender at birth ______________

Home Address ____

____

Preferred Phone ______________________ Alternate Phone ______________

Email Address ____

Employer ______________________ Occupation ______________

Preferred Language ______________________ Marital Status ______________

Religion ______________ Race ______________ Ethnicity ______________

Emergency Contact(s), relationship to patient, and phone number:

Advance Directives

Do you have a Durable Medical Power of Attorney, living will, and/or DNR? ☐ Yes ☐ No

If yes, a copy is requested for your medical record.

If no, would you like an information packet today? ☐ Yes ☐ No

Insurance Information

Primary Insurance: ______________________ Policy Number: ______________

Address *(on back of card)*: ____

Supplementary Insurance: ______________________ Policy Number: ______________

Address *(on back of card)*: ____

Policy Holder's Name: ______________________ Date of Birth: ______________

Financially Responsible Party *(If other than Patient)*

Full Name: ______________________ Home Phone: ______________

Street Address: ____

City: ______________________ State: ______________ Zip Code: ______________

By signing this form, I authorize the following:

a) the release of any medical or other information necessary to process insurance claims
b) payment of medical benefits directly to this practice for services rendered
c) the office of Elevated Primary Care may e-scribe medications as well as view my medication history using an electronic system

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Your insurance policy is a contract between you and your insurance company and we must abide by the contract terms you agreed to. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. WE REQUEST THAT FEES FOR OFFICE VISITS BE PAID AT THE TIME OF EACH VISIT.

You must provide us with complete and accurate insurance information in order for your claim to be submitted and processed. We will facilitate the claims process by filing for you. If your insurance company has not paid the claim in full within 60 days, you will be responsible for the balance.

By submitting this patient information form, you are agreeing to the following:

- That payment of authorized benefits will be made on your behalf.
- That the benefits to which you are entitled, including Medicare, private insurance, and other health plans, will be payable to Elevated Primary Care.
- That you are financially responsible for all charges, regardless of whether it is paid by your insurance.
- That the assignment/authorization will remain in effect until revoked by you in writing. A photocopy of this assignment will be considered as valid as the original.

THANK YOU FOR YOUR COOPERATION

Signature: ______________________________ Date: ______________________

Patient Intake Form

Patient information contained within this form are considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: ______________________ Date of Birth: ____________ Date (dd/mm/yr): ____________

Address: ______________________________ Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep

Home Phone: __________________ Work Phone: ________________ ☐ Male ☐ Female

Email: ____

Insurance: ____________________________ Employer: ____________________________

Occupation: ____

Reason for visit: ____

Past Medical History *(please list all current and prior diagnoses)*:

Past Surgical History *(including procedures)*:

Physician / Hospital / Facility Name	Date	Procedure	Reason

Date of last annual physical ____

Date of last bloodwork __________________________ Was anything abnormal? __________________________

Please list other physicians that you see including name and specialty:

Family History:

	Father	Mother	Brother	Sister	Children	Other
Autoimmune disorder						
Alcoholism						
Anemia						
Arteriosclerosis						
Arthritis						
Asthma						
Bleed easily						
Cancer						
Diabetes						
Emphysema						
Epilepsy/Seizure						
Glaucoma						
Heart disease						
High blood pressure						
High cholesterol						
Multiple sclerosis						
Osteoporosis						
Stroke						
Thyroid disease						
Other:						

Social History:

Tobacco Use:

Do you smoke cigarettes? ☐ Yes ☐ No Current Smoker? ☐ Yes ☐ No

Former Smoker? ☐ Yes ☐ No Packs per day: _______ Number of years: _____ Year quit: ________

Smoke Socially? ☐ Yes ☐ No Do you use smokeless tobacco? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No Number of years vaping? _______

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No If yes, how often and how much? ______________________________

Quit drinking alcohol? ☐ Yes (If yes, when ___________________)

Drug Use:

Do you smoke marijuana? ☐ Yes ☐ No If yes, how long have you smoked? ____________________

How often do you smoke? ____

Recreational/Illicit drugs (street drugs)? ☐ Yes ☐ No

Please list: ____

Caffeine:

Do you drink caffeinated beverages? ☐ Coffee ☐ Tea ☐ Soda

If yes, how much per day ______________

Are you sexually active? ☐ Yes ☐ No

Would you like to be checked for STDs/STIs/HIV? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

What do you do? How often?

____

Women:

1st day of your last period? ____________________ Cycle Length? ____________________

Are you pregnant or breastfeeding? ____

Date of last pap smear ____________________ Date of last mammogram ____________________

Date of last bone density scan ____________________ Date of last colonoscopy ____________________

Men:

Date of last prostate cancer screening ____________________ Date of last colonoscopy ____________________

Vaccination History (Note the date of the following if applicable):

Have you received the COVID vaccine? ☐ Yes ☐ No If yes, how many doses? ______________

Date of last FLU vaccine? ____________________ Date of last Pneumococcal vaccine? ____________________

Have you received the Shingles vaccine? ☐ Yes ☐ No

Preventive Care (Note the date of the following if applicable):

Date of last eye exam ____________________ Date of last dental exam ____________________

Date of last skin check by a dermatologist ____________________

Activities of Daily Living

Question	Yes	No
Do you wear contacts or glasses?	☐ Yes	☐ No
Do you drive?	☐ Yes	☐ No
Do you require assistance to prepare meals?	☐ Yes	☐ No
Do you need assistance with get dressed?	☐ Yes	☐ No
Do you need assistance to get out of bed?	☐ Yes	☐ No
Do you need assistance with Bathe?	☐ Yes	☐ No
Are you concerned about your balance?	☐ Yes	☐ No
Have you had a fall in the last twelve months?	☐ Yes	☐ No

List all medications you are currently taking:

List all allergies and your reaction

Preferred Pharmacy with address/phone:

Do you have any other health issues or concerns that our staff should be made aware of?

By signing below, I authorize Elevated Primary Care to contact me via email or telephone and may leave a voicemail message regarding appointments or test results. I consent to have requested medical records or test results sent to me via email or fax:

Patient Signature: ____ Date: ____________________

Email: ____ Fax #: ____________________

Acknowledgement of receipt of the Notice of Privacy (HIPPA) for Elevated Primary Care

Signature: ______________________________ Print Name ______________________________

Date: ______________________

Consent to Notify

In the course of your treatment as a patient of Elevated Primary Care, it may be necessary to contact you regarding your appointments or medical condition. Please designate those you authorize us to discuss or send your protected health information to upon request. Without this authorization, we are prohibited by law to speak to anyone on your behalf for any reason. This applies to spouses, children, parents and any other immediate family members or friends.

I, ____________________________________, hereby authorize the office of Elevated Primary Care to communicate with:

Name: __________________ Relationship: ____________________ Telephone: ________________

Name: __________________ Relationship: ____________________ Telephone: ________________

Name: __________________ Relationship: ____________________ Telephone: ________________

This authorization will last indefinitely unless this office is notified in writing about any new changes.

Patient Signature: ____ Date: ____________________