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**Adult New Patient Form**

**PATIENT INFORMATION**

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile # ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #. ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work #. ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY & CONTACT INFORMATION**

Sig Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Relationship] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SO Mobile # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact? [circle] **Y / N**

Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emer Contact # ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Demographic Information**

**Ethnicity**  **Race**

O *Decline to answer* O *Decline to answer* O *Black/African American*

O *Hispanic/Latino* O *American-Indian/Alaska Native* O *Native Hawaiian/Pacific Islander*

O *NOT Hispanic/Latino*  O *Asian* O *White* O *Other*

**Doctor & Pharmacy Information**

Current/Previous Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Phone #] ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Address] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[City] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [State] \_\_\_\_\_\_\_\_\_\_ [ZIP] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL active treating physicians (i.e. cardiologist, endocrinologist, gastroenterology, etc…)

Doctor’s NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your preferred PHARMACY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**Patient Financial Obligation Agreement**

1. Do you wish to become a **subscription** (non-insurance based) patient? **[ ] Y [ ] N**
2. NO billing for office visits
3. Labs
   1. Labs drawn in office:
      1. Low cost (cost + 20%) – NOT billed to insurance (in other words, “self-pay”)
      2. Usually MUCH less than your insurance co-pays
   2. If insured, you may opt to have your labs drawn at an outside lab.
4. Your insurance or health share is available for *referrals*, *outpatient medical services (such as physical therapy),* *ER visits* or *Hospital stays*.
5. Do you wish to become an **insurance-based** patient? **[ ] Y [ ] N**
   1. Your insurance must be accepted by Code 1 Concierge Care.
   2. All applicable co-pays and deductibles are due at the time of service.
   3. You agree to be financially responsible for all charges not covered by your insurance company.
   4. You authorize that your insurance benefits be paid directly to Code 1 Concierge Care for services rendered.
   5. You authorize release of pertinent medical information to your insurance company when requested in order to facilitate payment of a claim.

**I have read and agree to the above (Financial Agreement)**

Patient or Legal Guardian Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Medical Questions & Information**

**Reason for today’s visit?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medical Problems (check all that you can remember)**

[ ] Asthma/Reactive Airway Disease [ ] Lungs (COPD, Emphysema) [ ] Skin disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Cancer [ ] Liver Disease [ ] Immune disorder \_\_\_\_\_\_\_\_\_\_\_

[ ] Coronary Artery Disease (CAD) [ ] Pain (chronic)

[ ] Cholesterol (high) [ ] Seizure/Epilepsy

[ ] Eye disorder (Glaucoma, cataract) [ ] Stroke (CVA, TIA)

[ ] Diabetes [ ] Thyroid (low or high)

[ ] Gastritis/Ulcers [ ] Kidney failure

[ ] Gout [ ] Bladder disorder

[ ] Heart Failure [ ] Osteoarthritis

[ ] High Blood Pressure [ ] Rheumatoid arthritis

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Review of Systems** | | **Medical Questions and Information (cont)** | | | |  | |
| Please indicate ALL that you have experienced within the past 6 – 12 months. | | | | | | | |
| **Constitutional** | |  | |  | |  | |
| □Y□N | Fever | □Y□N | Fatigue | □Y□N | Weight Gain ( Lbs) | □Y□N Sleep Disturbances | |
| □Y□N | Chills | □Y□N | Feeling Poorly | □Y□N | Weight Loss ( Lbs) | □ Other: | |
|  | | □Y□N | Sweats | □Y□N Unexp. Weight Change | |  | |
| **Head, Eyes, Ears, Nose, and Throat** | | | | | | | |
| □Y□N | Vision Problem | □Y□N | Red Eyes | □Y□N | Congestion | □Y□N | Hoarseness |
| □Y□N Decreased Hearing  □Y□N Double Vision  □Y□N Light Sensitivity  □Y□N Itchy Eyes  **Cardiovascular** | | □Y□N | Eye Pain | □Y□N | Snoring | □Y□N Ringing in Ears | |
| □Y□N | Runny Nose | □Y□N | Dry Mouth | □Y□N Vertigo | |
| □Y□N | Neck Stiffness | □Y□N | Flu-Like Symptoms | □Y□N Earache | |
| □Y□N | Nosebleed | □Y□N | Sore Throat | □Y□N Other: | |
| □Y□N | Chest Pain | □Y□N | Cold Extremities | □Y□N | Irregular Heart Rhythm |  | |
| □Y□N | Palpitations | □Y□N | Cold Hands or Feet | □Y□N | Other: |  | |
| □Y□N | Leg Swelling | □Y□N | Leg Pain w/ Walking |  | |  | |
| **Respiratory** | |  | |  | |  | |
| □Y□N | Shortness of Breath | □Y□N | Wheezing | □Y□N | Coughing Up Blood | □ | |
| □Y□N | Cough | □Y□N | Shortness of Breath | □Y□N | Coughing Up Sputum |  | |
| □Y□N | Rapid Breathing | □Y□N | Chest Congestion | □ Other: | |  | |
| **Gastrointestinal** | |  | |  | |  | |
| □Y□N | Abdominal Pain | □Y□N | Diarrhea | □Y□N | Change in Bowels | □Y□N Painful Swallowing | |
| □Y□N | Blood in Stool | □Y□N | Black/Tarry Stools | □Y□N | Vomiting Blood | □ Other: | |
| □Y□N | Vomiting | □Y□N | Decreased Appetite | □Y□N | Bowel Incontinence |  | |
| □Y□N | Nausea | □Y□N | Yellow Skin | □Y□N | Rectal Pain |  | |
| **Neurological** | |  | |  | |  | |
| □Y□N | Headache | □Y□N | Unsteady | □Y□N | Numbness | □Y□N Tremor | |
| □Y□N | Dizziness | □Y□N | Disorientation | □Y□N | Tingling | □Y□N Tremor | |
| □Y□N | Decreased Strength | □Y□N | Confusion | □Y□N | Seizures | □ Other: | |
| □Y□N | Poor Coordination | □Y□N | Burning Sensation | □Y□N | Fainting (“syncope”) |  | |



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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Review of Systems** | | **Medical Questions and Information (cont)** | | | | 4/5 | |
| Please indicate ALL that you have experienced within the past 6 – 12 months. | | | | | | | |
| **Musculoskeletal** | |  | |  | |  | |
| □Y□N | Joint Pain | □Y□N | Limb Pain | □Y□N | Muscle Pain | □ Other: | |
| □Y□N | Chills | □Y□N | Joint Swelling | □Y□N | Muscle Weakness |  | |
| □Y□N Back Pain | | □Y□N | Muscle cramps | □Y□N Leg Swelling | |  | |
| **Genitourinary** | | | | | | | |
| □Y□N | Frequent Urination | □Y□N | Incr. night Urination | □Y□N | Vaginal Discharge | □ | Other: |
| □Y□N Incontinence  □Y□N Urinary Urgency  □Y□N Painful Urination  □Y□N Pelvic Pain  **Integumentary** | | □Y□N | Eye Pain | □Y□N | Vaginal Bleeding |  | |
| □Y□N | Genital Itching | □Y□N | Dry Mouth |  | |
| □Y□N | Change in libido | □Y□N | Irreg. Cycles |  | |
| □Y□N | Painful Intercourse | □Y□N | Heavy Period bleeding |  | |
| □Y□N | Rash | □Y□N | Skin Wound | □Y□N | Unusual Growth | □ Other: | |
| □Y□N | Dry Skin | □Y□N | Change in Mole | □Y□N | Itching |  | |
| □Y□N | Rash | □Y□N | Skin Wound | □Y□N Unusual Growth | |  | |
| **Psychiatric** | |  | |  | |  | |
| □Y□N | Depression | □Y□N | Anxiety | □Y□N | Suicidal Thoughts | □ Other: | |
| □Y□N | Poor Sleep | □Y□N | Racing thoughts | □Y□N | Hallucinations (auditory or visual) |  | |
| **Heme/Lymphatics** | |  | |  | |  | |
| □Y□N | Easy Bruising | □Y□N | Easy Bleeding | □Y□N | Swollen glands | □ Other: | |
| **Endocrine** | |  | |  | |  | |
| □Y□N | Excessive Thirst | □Y□N | Heat Intolerance | □Y□N | Cold Intolerance | □Y□N Hair changes | |
| □Y□N | Excessive sleep | □Y□N | Exhaustion | □Y□N | Other |  | |
| □Y□N | Constipation | □Y□N | Trouble Swallowing | □Y□N | Heartburn |  | |



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**Medical Questions & Information (cont)**

**Surgeries or Procedures**

|  |  |  |
| --- | --- | --- |
| **Surgery or Procedure** | **Year** | **Reason** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Family History – Illnesses**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relative** | **Condition and description** | **Living?** | | **If deceased, @ what age?** |
| Mother |  | □ Y | □ N |  |
| Father |  | □ Y | □ N |  |
| Sibling(s) |  | □ Y | □ N |  |
| Other: |  | □ Y | □ N |  |

**Smoking Alcohol Drugs**

* Currently smoke? □ Y □ N - Consume alcohol? □ Y □ N - Use drugs? □ Y □ N
* If not, previously? □ Y □ N - If YES, # drinks/week: - If YES, which:
  + Years?\_\_\_ Packs/day \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other tobacco? □ Y □ N - How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_