Intake Form

Patient Information

Last Name:	First Name:	Middle Initial	Date of Birth / /	Age:

Address (No PO Box Please)	City	State	Zip

Home Phone:	Work Phone:	Cell Phone:	Email

Social Security #:	Marital Status: Single☐ Mar☐ Div ☐ Sep☐ Wid ☐	Sex: M ☐ F ☐

Spouse's Name:

Home Phone:_____

Cell Phone_____

Employer: Occupation:

Address: City State Zip

Pharmacy Name/Address: City State Zip

Phone Fax

Have you sought legal advice for this problem? Yes ☐ or No ☐

Primary Care Physician:

Address: City State Zip

Phone Fax

Insurance Information

Please give your Insurance Card to the receptionist

Primary Insurance	Policy #	Group #	Secondary Insurance	Policy#	Group#

Claims Address:	Co Pay:	Claims Address:

City State Zip	City State Zip

Subscriber's Name:	Date of Birth:	Subscriber's Name:	Date of Birth:

Relationship to Insured: Spouse ☐ Child ☐ Other ☐ **Relationship to Insured: Spouse ☐ Child ☐ Other ☐**

How Did You Hear About Us?

Website ☐ Family ☐ MD ☐ Hospital ☐ Insurance ☐ Friend ☐ Other ☐

Referring Physician:	Address:
Phone:	Fax:

Emergency Information

Emergency Contact:	Relationship	Home#:	Cell#

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize the release of my medical information to my referring or treating physician. I hereby authorize my Insurance Company(s) to pay directly to Miracle Mile Medical Group or Integrative Surgical Associates Group, the medical or surgical benefits of any otherwise payable for services as described on my insurance form hereof, but not to exceed the charges for those services. I the undersigned understand that I am financially responsible for those medical and/or surgical charges incurred by me, or my dependent. All fees necessary to collect this account are payable by me.

Signature of Patient/Legal Guardian	Date:

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit?_____

2. Have you sought legal advice for this problem? ❑ Yes ❑ No

Are you PREGNANT, or is there a chance you could be pregnant? ❑ Yes ❑ No ❑ I would like a pregnancy test

Are you currently taking any blood thinning medications? ❑ Yes ❑ No If yes, please specify:_____

DO YOU HAVE ANY IMPLANTABLE DEVICES? ❑ Yes ❑ No If so, what and where? _____

PAST MEDICAL HISTORY (Please check any illnesses you have had): ❑ None

❑ Abnormal Bleeding
❑ Abnormal Clotting
❑ AIDS/ HIV
❑ Allergies/ Hay fever
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bronchitis
❑ Cancer_____
❑ Cholesteatoma
❑ COPD/Emphysema
❑ Chron's Disease
❑ Diabetes – *Insulin dependent*
❑ Diabetes – *non-insulin dependent*
❑ Ear infections
❑ Eczema
❑ Endometriosis
❑ Fibromyalgia
❑ Glaucoma
❑ Headaches
❑ Heart Disease
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Hypertension
❑ Hepatitis
❑ Irritable Bowel Syndrome
❑ Joint Disease
❑ Kidney Disease
❑ Laryngitis
❑ Lupus
❑ Migraines
❑ Multiple Sclerosis
❑ Otosclerosis
❑ Parkinson's Disease
❑ Parotid Swelling
❑ Psoriasis
❑ Recurrent Sinusitis
❑ Reflux (GERD)
❑ Throat Infections
❑ Seizures
❑ Sickle Cell Disease
❑ Skin Condition _____
❑ Sleep Apnea
❑ Snoring
❑ Stroke
❑ Thyroid Disease
❑ Ulcer
❑ Vasomotor Rhinitis

PAST SURGICAL HISTORY (Please check any surgeries you have had): ❑ None

Surgery/Date: _____ Surgery/Date: _____
Surgery/Date: _____ Surgery/Date: _____
Surgery/Date: _____ Surgery/Date: _____

MEDICATIONS (List all your current medications and the dose you take): ❑ **None** (please use back if needed)

Medication: _____ Medication: _____
Medication: _____ Medication: _____
Medication: _____ Medication: _____
Medication: _____ Medication: _____
Medication: _____ Medication: _____

ALLERGIES (List medications/foods you are allergic to and what happens when you take them): ❑ None

a) Medication_____ Reaction_____
b) Non-Drug Allergies_____
c) Do you have a history of anaphylaxis? ❑ Yes ❑ No
d) Do you have an allergy to latex? ❑ Yes ❑ No
e) Are you allergic to Iodine, Intravenous Dye, Contrast Dye, Shellfish (Shrimp/Lobster)? ❑ Yes ❑ No

FAMILY HISTORY (Check all illnesses that run in your family): ❑ None

❑ Alcoholism
❑ Allergies_____
❑ Asthma
❑ Bleeding Problems
❑ Cancer_____
❑ Diabetes
❑ Hearing Loss
❑ Heart Attack
❑ High Blood Pressure
❑ Migraines
❑ Psychiatric illness
❑ Sickle cell anemia
❑ Stroke
❑ Thyroid disease
❑ Vertigo
❑ Others_____
❑ Do not know family history

SOCIAL HISTORY:

Occupation /School:_____
Do you have an advance directive? ❑ Yes ❑ No
Marital status: ❑Married ❑Single ❑Divorced ❑ Widowed
How many alcoholic beverages do you drink each day?_____Stopped when:_____
Do you currently smoke? ❑ Yes ❑ No (❑ cigarettes, ❑ cigar, ❑ pipe) Social Smoker: ❑ Yes ❑ No
How much, and for how long have you smoked? _____Packs per day for_____years. Stopped when:_____
Do you chew tobacco? ❑Yes ❑ No
Do you use any recreational drugs?_____

Review of systems:

Constitutional: (**Please check all symptoms you currently have):**
❑ **None**
❑ Unexpected weight loss/weight gain (*Circle One*): _____pounds in the past ____weeks
❑ Night sweats ❑ Fatigue

EYES: ❑ **None**
❑ Wears glasses ❑ Swelling ❑ Eye pain ❑ Double vision
❑ Blindness ❑ Dryness of eyes ❑ Watery eyes ❑ Other: _____

ENT: ❑ **None**
❑ Allergies ❑ Ear pain ❑ Hoarseness ❑ Septal perforation ❑ Teeth problems
❑ Bleeding gums ❑ Facial pain ❑ Mouth sores ❑ Postnasal drip ❑ Throat pain
❑ Decreased/lost smell ❑ Gum disease ❑ Nasal congestion ❑ Rhinorrhea ❑ Voice changes
❑ Dentures ❑ Headaches ❑ Nasal discharge ❑ Ringing in ears/tinnitus ❑ Bad breath/taste
❑ Difficulty swallowing ❑ Hearing aids ❑ Nasal obstruction ❑ Snoring
❑ Dizziness/vertigo ❑ Hearing loss ❑ Nosebleeds ❑ Sore throat
❑ Ear drainage ❑ Heartburn ❑ Nose pain ❑ Sores on lips/gums
❑ Other _____

CARDIOVASCULAR: ❑ **None**
❑ Chest pain/pressure ❑ Palpitations ❑ Other _____

PULMONARY/RESPIRATORY: ❑ **None**
❑ Coughing blood ❑ Shortness of breath ❑ Other: _____

GASTROINTESTINAL: ❑ **None**
❑ Vomiting blood ❑ Use of antacids ❑ Blood in stool ❑ Appetite Changes
❑ Uncontrolled Bowel Loss ❑ Weight Change ❑ Constipation
❑ Other _____

GENITOURINARY:
❑ Pain of Urination ❑ Loss of Urine control ❑ Genital Lesions

MUSCULOSKELETAL: ❑ **None**
❑ Back pain ❑ Knee Pain ❑ Shoulder Pain ❑ Muscle Aches
❑ Other _____

SKIN: ❑ **None:**
❑ Change in mole ❑ Skin Lesions ❑ Rashes ❑ Other:_____

NEUROLOGICAL: ❑ **None**
❑ Head trauma ❑ Memory loss ❑ Numbness ❑ Syncope ❑ Fainting ❑ Vertigo

❑ Other: _____

PSYCHIATRIC: ❑ **None**
❑ Hallucinations ❑ Suicidal thoughts ❑ ***Fear of Needles*** ❑ Feeling Depressed
❑ Other: _____

ENDOCRINE: ❑ **None**
❑ Heat or cold intolerance ❑ Thyroid nodule ❑ Excessive Sweating ❑ Excessive Thirst
❑ Other: _____

HEMATOLOGY/LYMPHATIC: ❑ **None**
❑ Easy bruising ❑ Abnormal bleeding ❑ Enlarged lymph nodes ❑ Other: _____

ALLERGY/IMMUNOLOGY: ❑ **None**
❑ Eye discharge ❑ Itchy nose
❑ Itchy eyes ❑ Rashes ❑ Other: _____

`

Thank you for your time!