



COMPLETE CARE. ONE PLACE.  
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DAY	Date	Time
DOC:	Acct#	
Conf: Yes No	Staff:	

**GENERAL PATIENT/THYROID INTAKE FORM**

Full Legal Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Last Name First Name Middle Initial*

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

(H) Phone # (\_\_\_\_) \_\_\_\_\_ Mobile # (\_\_\_\_) \_\_\_\_\_ (circle one) Best # to reach you H or M

E-mail address: \_\_\_\_\_ Gender: Female \_\_\_\_ (Pregnant? \_\_\_\_) Male \_\_\_\_

Single \_\_\_\_ Married \_\_\_\_ Other \_\_\_\_ Spouse or Partner Name: \_\_\_\_\_

Employer / School: \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ circle which applies: (Full time/ Part time /Student/ Retired)

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#(\_\_\_\_) \_\_\_\_\_

Other than yourself, to whom may we disclose your Protected Health Information? \_\_\_\_\_

**Provide your PCP and current pharmacy information:** (if no PCP, please put N/A in "Family MD" area)

Family MD \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about us? (Please check all that applies) TV      Billboard      Radio      Internet  
OTHER \_\_\_\_\_

If referred by our patient, please print their name(s): \_\_\_\_\_

Is there any place you do NOT want us to leave a message? \_\_\_\_\_

**PLEASE PROVIDE YOUR INSURANCE CARD(S) TO FRONT DESK FOR SCANNING/COPYING**



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**HEALTH INSURANCE INFORMATION**

<p>Do you have medical insurance? Yes ___ No ___</p> <p>Do you have Medicare? Yes ___ No ___</p> <p>Insurance Company Name _____</p> <p>Insurance Company # _____</p> <p>Type of Insurance: HMO    PPO    POS    OTHER</p> <p>Policy# _____ Group# _____</p> <p>Policy Holders Name _____</p> <p>Their DOB: _____ Relationship _____</p>	<p>Do have any other insurance? Yes ___ No ___</p> <p>If Yes, complete below;</p> <p>Insurance Company Name _____</p> <p>Insurance Company Phone _____</p> <p>Type of Insurance: HMO    PPO    POS    OTHER</p> <p>Policy# _____ Group# _____</p> <p>Policy Holders Name _____</p> <p>Their DOB: _____ Relationship _____</p>
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**What are the concerns for which you are seeking care today? (Primary concern first)**

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_
2. \_\_\_\_\_ Date of onset: \_\_\_\_\_
3. \_\_\_\_\_ Date of onset: \_\_\_\_\_
4. \_\_\_\_\_ Date of onset: \_\_\_\_\_

**Medications and Supplements**

What medications (prescribed or over the counter) are you currently taking? Including Vitamins?


**Do you have any known contagious diseases at this time? Yes** (Explain)\_\_\_\_\_ **or No**



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Please check if you presently or have ever had any of the following symptoms.

**Checklist Self Review**

**GENERAL**

- Fatigue
- Fever/Chills
- Weakness
- Weight Loss
- Trouble Sleeping

**EARS**

- Hearing Loss
- Earache
- Discharge
- Ringing

**THROAT**

- Soreness
- Swallowing
- Infections
- Dryness
- Color Changes
- Sores/Lumps

**CHEST**

- Short Breath
- Cough
- Chest Pain
- Wheezing

**HEART**

- Cold Extremity
- Ankle Edema
- Murmur
- Varicosity
- Blood Clots
- Palpitations

**GENITOURIN**

- Urine Hesitancy
- Incontinence
- Urgency
- Frequency
- Kidney Stones

**WOMAN**

- Painful Sex
- Discharge
- Irregular Periods
- Hot Flashes
- Loss of Libido
- Dryness
- STD
- Last Period \_\_\_\_\_

**EYES**

- Blurry
- Double
- Pain
- Redness
- Change in Vision
- Flashing light/Specks
- Glasses or Contacts
- Cataracts
- Glaucoma
- Last eye exam \_\_\_\_\_

**NOSE**

- Bleeding
- Discharge
- Obstruction

**HEAD**

- Headaches
- Injuries
- Dizziness

**MOUTH**

- Bad breath
- Bleeding Gums
- Ulcers/ Sores
- Dental Problem
- Loss of Taste
- Sore Tongue
- Dry Mouth

**BREASTS**

- Lumps
- Pain
- Discharge
- Breast Feeding

**MUSCULOSKELETAL**

- Muscle or joint pain
- Stiffness
- Muscle Weakness
- Back Pain
- Swelling of joints
- Redness of Joints
- Trauma
- NECK**
- Pain
- Stiffness
- Swollen Glands
- Swallowing Difficulties

**MAN**

- Painful sex
- Hernia
- Discharge
- Erectile Dysfunction
- Pain or Masses
- STD

**ENDOCRINE**

- Heat or Cold Intolerances
- Excessive Thirst
- Excessive Sweating
- Trouble Sleeping

**NEUROLOGICAL**

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor

**RESPIRATORY**

- Cough (dry or wet)
- Sputum (color & amount)
- Coughing up blood
- Shortness of Breath
- Wheezing
- Painful Breathing

**PSYCHIATRIC**

- Nervousness
- Memory loss
- Stress
- Depression
- Anxiety

**GASTRIONTESTINAL**

- Nausea
- Black Stool
- Vomiting
- Jaundice
- Diarrhea
- Constipation
- Bloody Stool
- Heartburn
- Hemorrhoids
- Belching
- Abdominal Pain

**CARDIOVASCULAR**

- Tightness
- Palpitations
- Swelling
- Difficulty lying down
- Shortness of breath (rest)
- Shortness of breath (activity)
- Chest Pain

**VASCULAR**

- Calf pain when walking
- Leg cramping
- Swelling of leg

**HEMATOLOGICAL**

- Ease of bruising
- Ease of bleeding

**If yes to any symptoms, Please indicate if you are currently or in the past have experienced them:**



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**Family History** Please write appropriate letter to describe: E - Excellent G-Good F-Fair P-Poor

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
*Current Health							
Age at death							
Cause of death							

Please mark the number of family members on appropriate line:

**Please indicate if there have been any of the following diseases in you, your parents, grandparents, siblings, or children.**

\*Cancer \_\_\_ Diabetes \_\_\_ Epilepsy \_\_\_ Heart Disease \_\_\_ High Blood Pressure \_\_\_ Stroke \_\_\_ Anemia \_\_\_ Kidney Disease \_\_\_ Glaucoma \_\_\_ Allergies \_\_\_ Asthma \_\_\_ Mental Illness \_\_\_ Arthritis \_\_\_ Tuberculosis \_\_\_ Alzheimer's \_\_\_ HIV \_\_\_ Hepatitis \_\_\_ Joint Replacement \_\_\_ Bypass \_\_\_ Heart Attack \_\_\_

\*Please Specify \_\_\_\_\_

Have you had any surgeries? If so, please list: \_\_\_\_\_

Food, drug, or latex allergies? If so, please list: \_\_\_\_\_

Tobacco? \_\_\_ YES \_\_\_ NO How Often? \_\_\_\_\_ How Long? \_\_\_\_\_

Alcohol? \_\_\_ YES \_\_\_ NO If Yes, Type? \_\_\_\_\_ How Often? \_\_\_\_\_

Caffeinated beverages? \_\_\_ YES \_\_\_ NO If Yes, Type? \_\_\_\_\_ How Often? \_\_\_\_\_

Street Drugs \_\_\_ YES \_\_\_ NO If yes, please discuss with doctor



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**Complete Care Check** Based on health standards guidelines, you should be checked for the following.

Question	YES	NO	Pt. Response	Recommendation
Last Annual checkup?				
Do you have a primary care doc?				
Do you suffer from allergies?				
Do you suffer from fatigue?				
Do you wake up w/ pain or aches?				
Have you ever had any back or joint pain?				
Have you been screened for any suspicious spots, moles, lesions, or skin tags?				
Any family member been treated for any cancer?				
Have you smoked in the past?				
Have you had your (BMI Test) height and weight ratio test?				
Do you suffer from weight gain or loss?				
Do you suffer from mood swings?				
Do you feel stressed or feel it's too much to handle?				
Have you ever noticed a racing mind, fogginess, daydream, or forgetful?				
Do you find yourself limiting or avoiding activities due to how you feel?				
Have you had a Lyme test?				
Have you had a hearing test?				
Have you had a vision test?				
Have you had your flu vaccine?				

The patient or legal guardian must sign authorizations, such as in the case of a minor or when the patient is physically or mentally incompetent to sign. If patient is able to sign by marking an X, legal guardian must witness signature.

**Consent for Treatment**

The signature below authorizes consent to have your picture taken for the sole purpose of **identification**. This material **will not be sold or distributed for any reason**.

The information I have provided is complete and true to the best of my knowledge. I authorize the doctors and staff of Allegheny Medical, P.C. to administer such procedures and treatment as deemed necessary, or as required by my employer. There is no written, verbal, or implied guaranteed cure on our part. Due to our commitment to quality healthcare, we strive to improve services to our patients and we ask your consent prior to rendering treatment or services.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date: \_\_\_\_\_



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**Assignment of Benefits**

I \_\_\_\_\_ authorize Allegheny Medical, P.C. to be paid directly for services rendered. I accept responsibility for any service(s) that may not be covered by my health insurance, automobile insurance, or workers compensation carrier. I further authorize Allegheny Medical, P.C. to furnish information concerning my present illness or injury which may contact alcohol, drug, HIV or psychiatric related history to the insurer and health care providers involved in my care. I further direct the insurer to pay without equivocation directly to Allegheny Medical, P.C. any and all benefits due as a result of treatment and service(s) provided. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier. I hereby state and agree that a photocopy of this document will be deemed as valid and bindings on all parties involved as the original copy.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**Medicare Assignment of Benefits**

In accordance with the Medicare Act, Section 1842 (I) this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (II) (A) of the Medicare act. If Medicare determines that a particular service(s), although normally covered is not reasonable and necessary because the service(s) is maintenance in nature as defined by Medicare policy, Medicare will deny payment for those service(s). Medicare is likely to deny payment for service(s) that lack medical necessity. By my signature, I acknowledge notification by Allegheny Medical, P.C. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received and read "Notice of Privacy Practices" from Allegheny Medical, P.C.

\_\_\_\_\_  
DATE PRINT NAME OF PATIENT SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE

I decline to read or accept a copy of the "Notice of Privacy Practices" from Allegheny Medical, P.C.

\_\_\_\_\_  
DATE PRINT NAME OF PATIENT SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE



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# THYROID INTAKE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Do you Take Thyroid Medication? Please list brand, dosage and frequency.

Please indicate if you have any major or chronic illness listed below:	Yes	No	Previously
Diabetes			
High Blood Pressure			
Neurological Disease			
Heart Disease			
Respiratory Disease			
Gastrointestinal Disease			
Liver Disease			
Hepatitis			
High Blood Pressure			
Kidney Disease			
Hypothyroidism			
Hyperthyroidism			
HIV			
Glaucoma			

Insomnia	Yes	No	Previously
Cannot sleep until after 11pm			
Awaken between 11pm - 1am			
Awaken between 1-3 am			
Awaken between 3-5am			
Awaken between 5-7am			

Emotions	Yes	No	Previously
Irritability			
Grief			
Sadness/lack of joy			
Worry			
Fear			
Anger			

Do you use the following?	Yes	No	Previously
Nutrasweet			
Splenda			
Saccharine			
Diet Drinks			
MSG			
Trans Fats			
Soy			
Mercury dental fillings			
Fluoride toothpaste			
Fluoride dental treatments			

Do you have pain?

How would you rate? 1-10

Do you have any scars, tattoos or piercing's?

Women - Are you still having periods?

Men - do you have trouble with impotence?

Do you get up at night to urinate?

If so, how many times?