smartinfusion THERAPY SERVICES

Office Use Only
Date:
MRN:
ID Verified:

Patient Information

First Name: _____ Last Name: _____ MI: _____ DOB: _____

Address: _____City: _____State: _____ Zip: _____

☐ Male ☐ Female Marital Status: _____ Height: _____ Weight lbs/kg: _____

Phone: ☐ Cell ☐ Home _____ Email: _____

(I understand if information is emailed, there may be some level of risk that the information could be viewed by an unauthorized party and I accept these risks. By providing my contact information I authorize SITS, its physicians and staff to communicate with me electronically about my care, account and services.)

Referring Provider: _____ Referring Provider Phone: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Emergency Contact Relationship: _____

Insurance Coverage:

Primary
Insurance Co Name:_____
Insurance Phone: _____
Policy Holder Name: _____
Policy #: _____
Policy Holder DOB: _____
Relationship to Patient: _____
Insured's Employer: _____
Employer Phone: _____

Secondary
Insurance Co Name:_____
Insurance Phone: _____
Policy Holder Name: _____
Policy #:_____
Policy Holder DOB: _____
Relationship to Patient: _____
Insured's Employer: _____
Employer Phone: _____

Authorized Representatives

I authorize Smart Infusion Therapy Services to discuss my medical/financial information with the following individuals.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Contact Authorization

I authorize Smart Infusion Therapy Services and Staff to leave messages regarding my medical/financial information.

Home Phone ☐ No ☐ Yes **Cell Phone:** ☐ No ☐ Yes **Work Phone:** ☐ No ☐ Yes

I acknowledge the information provided above is true and accurate:

Name of person completing this form: _____ Relationship: _____

Signature of person completing this form: _____Date: _____

First Name: _____ Last Name: _____ MI: _____ DOB: _____

Allergy History

_____

_____

List Tried and Failed Medications (See page 3 for additional information)

Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____

List Any Medications/Supplements/Vitamins (See page 3 for additional information)

Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____

List Any Vaccinations Received in Last 6 Months

Name: _____ Received: _____
Name: _____ Received: _____

Surgery History

Year: _____ Description: _____
Year: _____ Description: _____

Smoking/Drinking History

Current Smoker? ☐ No ☐ Yes Former Smoker ☐ No ☐ Yes Pks/Day: _____ Age Quit: _____

Recreational Drugs? ☐ No ☐ Yes Type: _____ Frequency: _____

Drink Alcohol ? ☐ No ☐ Yes Drinks Per Week: _____

Patient Health History

Rheumatology
- ☐ Rheumatoid Arthritis
- ☐ Plaque Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Ankylosing Spondylitis
- ☐ Other _____

Gastroenterology
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Congestive Heart Failure
- ☐ GERD/Reflux
- ☐ Other _____

Endocrine
- ☐ Diabetes
  - ☐ Type A ☐ Type B
- ☐ Thyroid Disease
  - ☐ Hyper ☐ Hypo
- ☐ Grave's Disease
- ☐ A-Fib
- ☐ Other _____

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Pacemaker/Defibrillator
- ☐ Heart Disease
- ☐ A-Fib
- ☐ Other _____

Blood/Immune/Cells
- ☐ Iron Deficiency Anemia
- ☐ Hemophilia
- ☐ Easy Bruising
- ☐ HIV/AIDS
- ☐ Other _____

Respiratory
- ☐ COPD
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Other _____

Neurology
- ☐ Multiple Sclerosis
- ☐ Myasthenia Graves
- ☐ Seizures
- ☐ Migraines
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Other _____

Chronic Kidney Disease
- ☐ Stage 1
- ☐ Stage 2
- ☐ Stage 3
- ☐ Stage 4
- ☐ Dialysis

Allergy & Immunology
- ☐ Allergic Rhinitis
- ☐ CIPD
- ☐ Primary Immunodeficiency
- ☐ Systemic Lupus Erythematosus
- ☐ Hypogammaglobulinemia
- ☐ Hereditary Angiodema (HAE)
- ☐ Alpha1-antitrypsin deficiency
- ☐ Other _____

Skin Conditions
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives/Urticaria
- ☐ Other _____

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Other

☐ History of Cancer
Type: _____
_____
_____
_____

Supplemental/Additional Patient Information

First Name: _____ Last Name: _____ MI: _____ DOB: _____

Allergy History (Continued from page 2)

_____
_____
_____

List Tried and Failed Medications (See page 3 for additional information)

Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____

List Any Medications/Supplements/Vitamins (Continued from page 2)

Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____
Name: _____Dose: _____ Frequency: _____

List Any Vaccinations Received in Last 6 Months (Continued from page 2)

Name: _____ Received: _____
Name: _____ Received: _____
Name: _____ Received: _____

Surgery History (Continued from page 2)

Year: _____ Description: _____
Year: _____ Description: _____
Year: _____ Description: _____

Additional Information:

_____
_____
_____
_____
_____
_____
_____
_____