

## Intake and History Form

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

Street Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone Number (home): \_\_\_\_\_ Phone Number (mobile): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_

(For minors) Name of responsible party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_ Cardholder's Name: \_\_\_\_\_

Insured SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Insured SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

I authorize the release of medical or other information about me to the listed insurance provider(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

**Copays are due at time of service.** All accounts should be paid within 90 (ninety) days of insurance being posted to prevent further action. I/we agree to pay any collection or attorney fees owed in addition to court costs if charges are not paid within the terms stated above and legal action is necessary to obtain collection.

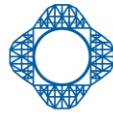
I/we give permission for my/our minor child to receive medical attention.

I/we certify that I/we have read all of the above and the information given is true.

**I understand that I may be charged a no-show fee of \$50 for an office visit and \$100 for a procedure visit if I miss or cancel my appointment with less than 48 hours notice.**

**Patient/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please bring your current insurance card, photo ID, and a copy of this paperwork to your appointment. We recommend arriving at least 10 minutes early to ensure you have plenty of time to check in.*



**Reason for your visit today:** \_\_\_\_\_

Name of Person/Provider who referred you: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Preferred Pharmacy**

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

Phone Number: \_\_\_\_\_ City or Zip Code: \_\_\_\_\_

**Primary Care Provider:**

Facility: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Phone Number: \_\_\_\_\_

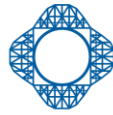
**Past Medical History (select all applicable)**

- |                          |                          |                              |
|--------------------------|--------------------------|------------------------------|
| Arthritis                | Atrial Fibrillation      | Prostate cancer              |
| COPD                     | Stroke                   | Non-alcoholic fatty liver    |
| Depression               | Congestive Heart Failure | Polycystic ovarian syndrome  |
| Diabetes                 | DVT–Deep vein thrombosis | Systemic lupus erythematosus |
| End-stage kidney disease | COVID 19 infection       | Bone marrow transplant       |
| Hypertension             | Epilepsy                 | Other: _____                 |
| HIV infection            | Migraines                | _____                        |
| High Cholesterol         | Hearing loss             | _____                        |
| Leukemia                 | Hyperthyroidism          | _____                        |
| Lymphoma                 | Hypothyroidism           | _____                        |
| Cancer of Colon          | Hepatitis                | _____                        |
| Anxiety                  | Breast cancer            | _____                        |
| Asthma                   | Lung cancer              |                              |

**Past Surgical History (select all applicable)**

- |                              |                                    |                        |
|------------------------------|------------------------------------|------------------------|
| Colectomy                    | Lumpectomy of breast               | Left hip replacement   |
| Coronary artery bypass graft | Mastectomy of left breast          | Left knee replacement  |
| Kidney transplant            | Mastectomy of right breast         | Right hip replacement  |
| Colostomy                    | Mechanical heart valve replacement | Right knee replacement |
| Tubal ligation               | Oophorectomy                       | Heart transplantation  |
| Appendectomy                 | Prostatectomy                      | Liver transplantation  |





**Review of Systems:**

Pregnant or planning a pregnancy	Yes	No	Premedication prior to procedures	Yes	No
Blood thinners	Yes	No	Rapid heart beat with epinephrine	Yes	No
History of MRSA	Yes	No	Immunosuppression	Yes	No
History of HIV infection	Yes	No	Fainting with procedures	Yes	No
History of Hepatitis B infection	Yes	No			
History of Hepatitis C infection	Yes	No	Fever or chills	Yes	No
Artificial heart valve	Yes	No	Sore throat	Yes	No
Artificial joints in the last 2 years	Yes	No	Cough	Yes	No
Defibrillator	Yes	No	Anxiety	Yes	No
Pacemaker	Yes	No	Shortness of breath	Yes	No
Allergy to adhesive	Yes	No	Problems with bleeding	Yes	No
Allergy to lidocaine	Yes	No	Hypertrophic/keloid scarring	Yes	No
Allergy to antibiotic ointment	Yes	No	Rash	Yes	No
Allergy to latex	Yes	No			
Have you received a Flu Shot within the last year?	Yes	No			
Have you received the Pneumonia Vaccination within the last 10 years?	Yes	No			

**Authorization and Privacy Notice**

In an effort to protect each person’s privacy, 4BDC sta are not allowed to give information on any patient, whether by phone or in person, without the written permission from the patient. We will not allow a person other than yourself to pick up medical records, test results, disability forms, prescriptions, etc., unless prior written consent is obtained from you, the patient or responsible party.

*Please specify the people you are giving written permission for:*

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

Do we have your permission to call your home/work/cell to discuss appointments, scheduling of tests and/or procedures as well as results of tests and/or procedures? **Yes** (specify preferred #) \_\_\_\_\_ **No**

May we leave a message at your home to persons other than yourself and/or on an answering machine to call our office? **Yes** **No**

I acknowledge receiving/being offered today a copy of the Provider’s Notice of Privacy Policies. I may request a copy at the front desk or view it on 4bridgesderm.com. By signing below, I am authorizing the practice to disclose my protected health information to the persons I have listed above or to other health care providers involved in my medical treatment. I understand my rights and how to revoke this permission as described in the Notice of Privacy Practices offered to me by the practice.

<b>Patient/Guarantor Signature:</b> _____	<b>Date:</b> _____
---	--------------------