Modern Family Medicine 7522 E. 1st St, Scottsdale, AZ 85251 P (602) 363-1631

New Patient Intake Forms

This information will be scanned into the electronic medical record.

Date:_____

Patient Information

Name:_____
Preferred Name:_____ Sex:_____
DOB:_____ SSN:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____Cell Phone:_____
Email:_____
Occupation:_____
Referred by/How did you find us?_____

Insurance Information

Primary insurance company:_____ policy #:_____ group#:_____
Secondary insurance company:_____ policy #:_____ group#:_____
Party responsible for payment's home address:_____
City:_____ State:_____ Zip:_____
DOB:_____ SSN:_____
Employer:_____ Relationship to patient:_____

Preferred Pharmacy

Pharmacy:_____
Address:_____
Phone Number:_____

I agree to be responsible for any charges for services and materials supplied by Modern Family Medicine and its providers for the above patient.

_____ _____
Patient acknowledgement (Signature) (Date)

Personal Health History

Previous Primary Care Provider:_____Last seen:_____
Name of Practice:_____ Phone Number:_____

Please list all providers you've seen below:

Provider Name	Practice Name/Address/Phone Number	Specialty

Medications

Please list all prescribed and over-the-counter medications you take regularly. *Please include all supplements, vitamins, or herbal products.*

Medication	Dose	Frequency	Medication	Dose	Frequency

Allergies to Medications

Do you have medication allergies? ☐ Yes ☐ No If yes, please list:

Medication	Reaction	Medication	Reaction

Substance Use

Product	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Concerns about your usage?
Tobacco					
Electronic Cigarettes/ Vape					
Alcohol					
Recreational Drugs					
Medical Marijuana					
Caffeine					
Other:					

Current Medical Conditions

(ex: diabetes, heart disease, hypertension, etc.) Date:

Past Medical/Surgical History

(ex: hospitalizations, illnesses, surgeries, etc) Date:

Gyn/Obstetrical History

	Yes/No	Date:		Yes/No	Date:
Vaginal birth			Miscarriage/Stillbirth		
Cesarean section			Pregnancy termination		
Abnormal pap			Other GYN procedures		

Preventative Health

Do you routinely wear a seat belt? ☐Yes ☐No

Testing:	Date:	Vaccines:	Date:
Pap/pelvic Exam		Tetanus Vaccine (Td, Tdap)	
Mammogram		Pneumonia Vaccine	
Colonoscopy		Zoster (Shingles) Vaccine	
Last wellness		Hepatitis A or Hepatitis B	
Last lab work		Covid Vaccine	
Prostate Specific Antigen		MMR	
Bone Density (Dexa)		Gardasil (HPV)	
Eye Exam		Flu vaccine	
Cardiovascular Stress Test		Other	

Family History (Have close relatives had the following?)

	Yes	Indicate which relative and maternal or paternal side	Still living?
Genetic Disorder			
Heart Attack			
High Cholesterol			
Thyroid Disease			
Cancer- specify type			
Kidney Disease			
Osteoporosis			
Rheumatoid Arthritis			
Asthma			
Mental Health Disorder			
Substance Abuse			
Stroke			
High Blood Pressure			
Dementia			
Alzhimers			
EDS/Hypermobility			
Other			

Review of Systems

Please check any of the following **current** symptoms (**within the past 3 months**).

General		Gastrointestinal	
Fever		Diarrhea	
Sweats at night		Constipation	
Hot flashes		Heartburn	
Temperature intolerance		Nausea	

Excessive thirst		Blood in stool	
Fatigue		**Genitourinary**	
Sleep difficulties		Pain or burning on urination	
Daytime sleepiness		Frequent urination	
Unplanned weight change		Waking to urinate at night more than once	
Skin		Excessive urination	
Rash		Difficulty emptying bladder	
New or changing moles		Urinary incontinence	
Eyes		Decreased sexual desire	
Pain		Pain with intercourse	
Redness		Sexually transmitted disease	
Vision changes		Fertility issues	
Ear, Nose, Throat		**Men:**	
Hearing loss		Erectile dysfunction	
Ringing in ears		**Women:**	
Dizziness or vertigo		Heavy vaginal discharge	
Bleeding gums		Heavy menstrual bleeding	
Nosebleeds		Painful menstrual periods	
Breast		Irregular menstrual bleeding	
Breast pain		**Musculoskeletal**	
Masses and or lumps		Generalized all over pain	
Nipple discharge		Joint pain	
Cardiovascular		Stiffness	
Chest pain		Joint swelling	
Heart murmur		Joint redness	
Irregular heart beat (palpitations)		Back pain	
Leg swelling or edema		Neck pain	
Pulmonary		Hypermobility	
Wheezing		**Neurological**	
Shortness of breath		Abnormal gait (trouble walking)	
Chronic cough		Falls	
Hematopoietic		Headaches	
Swollen lymph glands		Migraine	
Blood clots		Seizures	
Excessive bleeding		Muscle weakness	
Psychological		TIA	
Mood swings (describe)		Stroke	
Anxiety		Fainting or loss of consciousness	
Depression		Localized numbness	
Memory loss		Tingling/Neuropathy	

What health issues do you want to focus on during this visit?

_____

_____

_____

_____

_____

Trauma History

Have you ever been the victim of trauma or abuse including sexual, emotional, physical abuse, or neglect and/or being the victim of an accident, violent crome, or a natural disaster? ☐ Yes ☐ No

Is this an active issue in your life that you would like to address while you are here? ☐ Yes ☐ No

_____
_____
_____

Nutrition History

Please list everything you ate or drank in the last 24 hours:

Morning:
Afternoon:
Evening:
Snacks:

Please list any **food allergies** (that were treated with antihistamines or Epi-pen)

_____
Reaction _____
Please list any **food sensitivities** _____
Reaction _____
Do you currently or have you ever had a problem with weight or eating? ☐ Yes ☐ No
If yes, please describe:_____
Are you comfortable with your relationship with food? ☐ Yes ☐ No
Do you feel knowledgeable about your nutrition needs? ☐ Yes ☐ No

Movement, Exercise, and Rest

Please describe your usual physical activity:

Activity	How often?	How long each time?

How many hours of sleep do you usually get each night?_____
Do you have any sleep issues? If yes, please describe. _____

Physical Environment

Do you have specific health concerns about your current home or environment? (Quality of air, water, etc.)?

_____
Have you had hazardous environmental or occupational hazards? If yes, please describe.

_____

Relationship History

Relationship Status:_____ If married or partnered, what is your relationship length?_____

Are you sexually active? ☐ Yes ☐ No Are you happy with your sexual life?_____

Number of children and ages?_____

Do you want to have or have more children? ☐ Yes ☐ No

Do you use birth control? ☐ Yes ☐ No If no, are you interested in

Occupation History

Current or Past Occupation:_____

Still working?_____

Are you happy with your occupation?_____

Spirituality

Do you have a racial/cultural heritage that is important to you?_____

Do you identify with a specific religion? ☐ Yes ☐ No If so, which one?_____

What things or activities bring you your greatest joy and meaning?_____

What things create the greatest challenges for you?_____

Mind-Body Connection

Rate the amount of stress in your life: ☐ None ☐ A Little Bit ☐ Moderate ☐ Quite a Lot ☐ Extreme

How well do you manage stress?: ☐ Not at all ☐ A Little Bit ☐ Moderate ☐ Quite Well ☐ Excellent

What are the main sources of stress in your life?_____

What are your methods of coping with stress?_____

Health Goals

What are your overall goals for improving your health and your life?

_____

_____

_____

_____

Modern Family Medicine

Notice of Privacy Practices Acknowledgment Form HIPPA

I acknowledge that I have received a copy of the Modern Family Medicine notice of privacy practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

Patient acknowledgement (Signature) (Date)

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I understand that as a condition to my receiving treatment from Modern Family Medicine, Modern Family Medicine may use or disclose my personal identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of Modern Family Medicine. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me. While I am here, I permit the employees, doctor, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personal identifiable health information," refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, prest, or future physical or mental health or conditions of payment for provision of healthcare. The information identifies me, or there is a reasonable basis to believe that the information identifies me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting Modern Family Medicine to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request Modern Family Medicine to restrict how my health information is used or disclosed. Modern Family Medicine does not have to agree to my request for the restriction, beautiful Modern Family Medicine does agree, Modern Family Medicine is bound to abide by the restriction agreed.

I understand that Modern Family Medicine participates in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing at any time. My revocation/withdrawal will be effective except to the extent that Modern Family Medicine has taken action in reliance on my consent for use of disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Patient acknowledgement (Signature) (Date)

Medicare lifetime consent & Medicaid

I certify that the information given by me in applying under Title XVII of the Social Security Act is correct, and I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers as needed for this or a related Medicare claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient acknowledgement (Signature) (Date)