Medical Intake Form

_____ _____ _____
Print Name Date of Birth (MM/DD/YYYY) Gender

_____
Street Address City State Zip

_____ _____
Home Phone Cell Phone

_____ _____
Preferred Email Social Security Number

Activate Our office Patient Portal Account Yes____ No ____

Ethnicity: _____ Preferred Language: _____
Race: _____ Marital Status: _____
****Information collected for census purposes*****

Emergency Contact Information:
Emergency Contact:_____ Relationship to Patient: _____
Phone Number: _____

I authorize release of my personal information including HIPPA information to the individuals listed below.
Emergency Contact:_____ Relationship to Patient: _____
Phone Number: _____

Pharmacy Information
Preferred Pharmacy: _____ Phone:_____
Address/Cross Streets:_____

Insurance Information:
Primary Ins Carrier: _____
Subscriber name:_____
Subscriber Relationship to Patient _____
Subscriber # _____
Group #: _____

Secondary Ins Carrier: _____
Subscriber name:_____
Subscriber Relationship to Patient _____
Subscriber # _____
Group #: _____

_____
Patient/ Personal Representative/ Guardian – Please Print Name

_____ _____
Patient/Personal Representative/Guardian (Signature or key if electronic) Date

Medical History

What medical conditions do you have? □None (Skip this section)

□Diabetes Type I
□Diabetes Type II
□High Blood Pressure/Hypertension
□High Cholesterol
Emphysema □Heart Disease
□History of Stroke
□History of Heart Attack
□Hepatitis A
□Hepatitis B
□Hepatitis C
□Liver Disease_____
□Pancreatitis
□Kidney Disease_____
□Breast Disease_____
Syndrome
□Other medical conditions not listed:

□Thyroid Disease_____
□Migraines
□Blood clots
□Chronic Pain _____
□Arthritis
□Osteoporosis
□Autoimmune Disease_____
□Epilepsy
□Traumatic Brain Injury
□Pituitary Adenoma
□Alzheimer's or Dementia
□Hearing Impairment
□Blindness
□Intersex Condition_____

□Sleep Apnea
□Allergies
□Asthma
□COPD or
□Tuberculosis (TB)
□Cancer _____
□HIV or AIDS
□HSV (Herpes)
□Endometriosis
□Fibroids
□Polycystic Ovarian Syndrome (PCOS)
□Incontinence
□Hemorrhoids
□Irritable Bowel

_ Mental Health History

What mental health conditions do you have □None (Skip this section)

□Depression
□Anxiety
□PTSD
Disorder □Bipolar I
□Bipolar II
□Obsessive Compulsive Disorder
□Other mental health conditions not listed:

□Schizoaffective Disorder
□ADD/ADHD
□Autism Spectrum
□Eating Disorder
□Substance Use Disorder (sober or currently using)
□Alcoholism (sober or currently using)

Allergies

What are your allergies and what is your reaction? □None (Skip this section)
Medications _____
Foods _____
Animals/Insects _____
If your allergic reaction is anaphylaxis, do you have an epi-pen? □Yes □No

Medications

What medicines (prescription and over-the-counter) do you take (regularly and as needed)? ☐None (Skip this section)

Name	Dose	How Often?	What is it for?

Patient Authorization for Disclosure of Protected Health Information

Patient:

Legal Name: _____
Date of Birth: _____
(Address) _____
(Phone) _____

Prior Doctor/Provider Releasing Information:

(Name) _____
(Address) _____
(Phone) _____ (Fax) _____

Release Information:

- ☐ Complete Medical Record
- ☐ Medical Records for Past Year
- ☐ Other Records _____

Purpose: _____
_____

I specifically authorize the release of data and information relating to (check all that apply):

- ☐ Mental Health Records
- ☐ Substance Use Disorders
- ☐ HIV/AIDS test results
- ☐ Sexually Transmitted Diseases

Information Sent To:

(Name)_____Community Healthcare Partners_____
(Address) _____3901 Faulkner Dr, Lincoln, 68516
(Phone) _____(402) 858-4044 Lincoln _____(531) 213-4125 Omaha_____
(Fax) _____(402)858-4043_____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Prohibition on Conditioning of Authorization: The health care provider will not condition treatment on your signing this authorization, unless: The only reason the facility is providing you with health care is to make a report to a third-party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Expiration: This authorization will expire one year from the date signed unless the facility receives a Revocation as outlined below.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the Entity specified on this release. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

_____ _____

Patient/Personal Representative/Guardian (Signature or key if electronic) Date

_____

Patient/ Personal Representative/ Guardian – Please Print Name