NEW PATIENT INFORMATION (Medicare)

Name (Legal) _____ Prefer to be called: _____

Date of Birth: _____ Sex: Male Female

Address: _____ City, State, Zip: _____

Preferred Phone: _____ (circle) Cell Home Work

Alternate Phone: _____ (circle) Cell Home Work

Do we have your permission to leave a message on the preferred phone number above: YES NO

Email Address:_____ (Required if you want access to patient portal)

Employment Status: Retired Employed Employer: _____

Primary Care Physician: _____ Referring Physician: _____

Do we have permission to discuss your medical condition with anyone but yourself: YES NO

If yes, Whom: _____ Relationship:_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Language: English Spanish Other: _____

Ethnicity: Are you Hispanic/Latino YES NO

Race: White Asian American Indian/Native Alaskan Native Hawaiian/Pacific Islander Other: _____

RESPONSIBLE PARTY – IF DIFFERENT FROM PATIENT

Name _____ Relationship to Patient: _____

Address: _____ City, State, Zip: _____

Phone: _____ Cell Home Is it OK to leave a message? YES NO

INSURANCE INFORMATION

Name of Insured: _____ DOB: _____

Insured's Employer: _____

Sex: Male Female Relationship to Patient: Self Spouse Parent

Please turn over and complete page 2.

MEDICARE QUESTIONNAIRE

YES NO

☐ ☐ Do you or your spouse work in a company which has more than 20 employees and have insurance coverage thru that employer?

☐ ☐ Are you covered by another insurance which makes Medicare secondary?

☐ ☐ Is this illness covered by the VA (Veteran's Administration)?

☐ ☐ Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?

☐ ☐ Is this illness due to an automobile accident?

☐ ☐ Is this illness due to an injury at work?

MEDICARE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid services, or it's intermediaries or carriers, any information needed for this or a related Medicare claim. 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

General Authorization to Release Medical Information

I authorize the release of medical information to my primary care physician, referring physician, and consultants if needed, and as necessary to process any non-Medicare insurance claim, application or prescription.

Signature: _____

Relationship to Patient: Self Other: _____

Date: _____

NOTICE OF PRIVACY PRACTICES - HIPAA Notice

A printed copy of Dr. Strnot's Notice of Privacy Practices is available upon request.
Do you want a copy for your records: YES NO

HISTORY AND INTAKE FORM

NAME:_____ DATE OF BIRTH:_____

PHARMACY (INCLUDE LOCATION):_____

PAST MEDICAL HISTORY (circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Cancer: _____
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
GERD (Acid reflux)
Hearing loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Thyroid Problems
Pacemaker
Radiation Treatment
Seizures
Stroke
Valve Replacement
Other: _____
NONE (Please circle if none of the above applies)

PAST SURGERIES (Please list and give approximate date)

_____ _____
_____ _____
_____ _____
_____ _____

SKIN DISEASE HISTORY (circle all that apply)

Acne
Actinic Keratoses – Pre Skin Cancers
Asthma
Basal cell skin cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other_____

Do you wear Sunscreen? YES NO If yes, what SPF? _____
Do you tan in a tanning bed? YES NO
Do you have a family history of Melanoma? YES NO
If yes, which relative(s)?_____
Any other family history _____

OVER

Please circle any conditions/problems you currently are experiencing:

NAME: _____

DATE: _____

Problems with Bleeding

Problems with Healing

Problems with Scarring (Hypertrophic or Keloid)

Rash

Immunosuppression

Hay Fever

Chest Pain

Fever or Chills

Night Sweats

Unintentional Weight Loss

Thyroid Problems (Hyper)

Thyroid Problems (Hypo)

Sore Throat

Blurry Vision

Bloody Urine

Abdominal Pain

Diabetes

Joint Aches

Muscle Weakness

Neck Stiffness

Headaches

Seizures

Cough

Shortness of Breath

Wheezing

Allergy to Latex, Band-Aids or Adhesive

Allergy to Lidocaine

Allergy to Topical Antibiotics Ointments

Allergy to Vicryl Suture

Artificial Heart Valve

Artificial Joints Within Past 2 years

Blood Thinners

Pacemaker or Internal Defibrillator

MRSA

Premedication Prior to Procedures

Rapid Heartbeat with Epinephrine

Oral or Implanted Birth Control

Pregnancy or Planning a Pregnancy

Breast Feeding

None

MEDICATIONS – If you brought a list, we will take a copy of it, otherwise please list below and include the dosage.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES TO MEDICATIONS – INCLUDE REACTION

_____

_____

_____

_____

_____

_____

_____

_____

Cigarette Smoking (Please circle):

Never smoked
Quit: former smoker
Smokes less than one daily
Smokes daily